Providing Medicaid Coverage & Reimbursement for Medical Respite in Oregon

Presented to the Joint Task Force on Hospital Discharge Challenges July 30th, 2024

ATI Advisory

REFRESHER ON TASK FORCE CONVERSATIONS TO-DATE REGARDING MEDICAL RESPITE

- In April, ATI presented on medical respite as an alternative to existing post-acute care settings that may not be appropriate nor able to support individuals experiencing homelessness and other complex care needs.

- The Task Force expressed interest in ATI further discussing medical respite, and opportunities that may present for Oregon to leverage medical respite within the care continuum to support appropriate hospital discharge.

TODAY'S AGENDA

- → Overview of Medical Respite: Defining Terms and Opportunities for Alleviating Hospital Discharge Delays
- → Current State of Medical Respite in Oregon
- → State Pathways to Promote and Cover Medical Respite Care
  - Existing Medicaid Flexibilities
  - New CMS Approval Required
- → Moving Forward

Overview of Medical Respite: Defining Terms & Opportunities for Alleviating Hospital Discharge Delays

MEDICAL RESPITE PROVIDES CONTINUING CARE OPTIONS FOR THOSE EXPERIENCING HOMELESSNESS

Medical Respite

- Provides acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover from a physical illness or injury, but not ill enough to be in a hospital
- Closes the gaps between hospitals / emergency departments and homeless shelters that lack the capacity and licensing to provide medical and support services needed for recuperation

Models of Medical Respite typically fall into the following categories, as defined by states and CMS:

Short-Term Post-Hospitalization Housing

- Short-term *housing* for individuals who do not have a residence to continue recovery from physical, psychiatric, or substance use conditions following
- May include ongoing physical and behavioral health services; typically includes wraparound services and case management

Recuperative Care

- Short-term residential care *with ongoing medical care*, such as medication monitoring, wound care, monitoring vital signs, supporting nutrition and diet, and other physical and behavioral health services

Medical respite evidence shows reductions in hospital readmissions, ED visits, and lengths of stay while improving housing status.

→ ***Local Spotlight:*** ShelterCare Medical Recuperation in Eugene reported serving **101 unhoused individuals** last year and saving over **$2 million in medical costs** to the health care system.

Source: Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care, NIMRC. CalAIM Approval, CMS. Medical Respite Programs for Homeless Patients: A Systematic Review, Doran et al. ShelterCare Medical Recuperation, ShelterCare.

MEDICAL RESPITE OFFERS SAFE DISCHARGE OPTIONS FOR THOSE WHOSE NEEDS EXCEED CURRENT CARE CONTINUUM OPTIONS

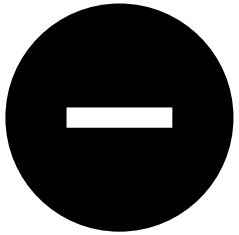
Medical Respite

Provides a safe recovery and recuperation environment for individuals experiencing homelessness who are falling through the cracks in the existing delivery system.

Scaling such models creates alternative post-discharge options for individuals with complex care needs, when level of care needs either exceed or are not appropriate for common post-acute care providers.

*Medical respite care **is**:*

- Short-term, following discharge from an institution or medical facility (e.g., Skilled Nursing Facility (SNF), in-patient acute hospital)
- For individuals who are independent in their activities of daily living (ADLs)
- Housing (24-hour access to bed, 3 meals a day); transportation; care coordination / case management, connections to primary care, community behavioral health, other services; navigation support for public benefits
- Daily wellness checks
- *May include:* onsite clinical services, onsite substance use treatment and behavioral health care



*Medical respite care is **not:***

- SNF, Nursing Home, Assisted Living, Long-term Care, or Supportive Housing *(although these settings may also be Medical Respite providers)*
- Intended for individuals with nursing facility level of care need (NFLOC)
- Temporary or transitional housing only

Sources: Best Practices in Medical Respite Care Service Delivery, Gilvar Consulting. Clinical Guidelines for Medical Respite / Recuperative Care, NIMRC. Standards for Medical Respite Programs, NIMRC.

Current State of Medical Respite in Oregon

TODAY, MEDICAL RESPITE IN OREGON IS FUNDED THROUGH THREE KEY PATHWAYS

→ State General Fund dollars, Coordinated Care Organizations (CCOs), and non-profit organizations play a critical role in funding and providing medical respite services in Oregon

1 State General Fund Grants and Investments

- **Project Turnkey 2.0 Grant Funding** has enabled new medical respite beds at non-profit shelter providers
- **Office of Resilience and Emergency Management** within ODHS used general fund dollars during COVID to provide housing (no services) to those needing a safe place to recuperate following hospitalization

2 CCO Approaches

- **SHARE Profit Reinvestment Initiatives** require a portion of CCO's profit be spent on housing-related services (some CCOs investing in Medical Respite providers / facilities)
- CCOs use flexibility within global budgets to provide **health-related services** (HRS) such as temporary housing assistance
- CCO **wrap around services** support with care navigation and transitions between services

3 Other Grants, Partnerships, and Non-Profit Efforts

- **Grants from Bezos Day 1 Families Fund and Project Turnkey 2.0** helped Mid-Willamette Valley Community Action Agency expand shelter bed capacity
- Other non-profit medical respite providers in Oregon report receiving support from **hospitals, CCOs, and private donors** to support their operations

Sources: Comparing CCO spending initiatives, OHA. 2024 SHARE Initiative Guidance for CCOs, OHA. Medical Respite Providers in Oregon, NIMRC. Mid-Willamette Valley Community Action Agency Delivers Relief, Oregon Community Foundation. Salem-area nonprofit gets record $5 million grant, Statesman Journal.

CCOs, STATE GENERAL FUND INVESTMENTS, AND NON-PROFIT PROVIDERS SUPPORT MEDICAL RESPITE ON A LIMITED, REGIONAL BASIS WITHIN THE CURRENT DELIVERY SYSTEM

Hospital Discharge

- Individual needs ongoing wound care, medication monitoring, and Behavioral Health Services
- Individual does not have a secure residence to recuperate
- ***Hospital and CCO coordinate discharge planning***

✓ Medicaid benefit
✓ CCOs (HRS / SHARE)
✓ General Fund
✓ Non-Profit Organizations

Recuperative Care

- Individual is placed in Medical Respite Recuperative Care facility for 90 days to address ongoing clinical and Behavioral Health needs
- ***Services provided by non-profit shelter provider (<u>if available in region</u>); may be supported by CCO HRS / SHARE***

❑ Medicaid benefit
✓ CCOs (HRS / SHARE)
✓ General Fund
✓ Non-Profit Organizations

Short-Term Post Hospitalization Housing

- Once acute needs are addressed, individual can transition to less intensive environment for continued support in a facility setting (generally up to 6 months)
- ***Services provided by non-profit shelter provider (<u>if available in region</u>); may be supported by CCO HRS / SHARE***

❑ Medicaid benefit
✓ CCOs (HRS / SHARE)
❑ General Fund
✓ Non-Profit Organizations

Rental Assistance & Housing Supports[1]

- Individual supported by CCO Housing Navigation, Pre-Tenancy, Tenancy Sustaining Services
- Independent housing with financial assistance and case management to maintain independence[1]
- ***May be supported by CCO HRS / SHARE***

❑ Medicaid benefit
✓ CCOs (HRS / SHARE)
❑ General Fund
✓ Non-Profit Organizations

CCO Health-Related Services (HRS) & wrap-around services support individuals as they transition between services. Some CCOs may use HRS to pay for temporary, transitional housing.

❑ Not in place today
✓ In place today

HRSN – Health-Related Social Needs; **SHARE –** Supporting Health for All through Reinvestment

1. Planned HRSN rental assistance benefit (Nov 2024) does not include those currently homeless; individuals must be currently housed and at risk for homelessness.

State Pathways to Promote Medical Respite Care (Existing Medicaid Flexibilities)

OPPORTUNITIES TO PROMOTE MEDICAL RESPITE WITHIN EXISTING MEDICAID FLEXIBILITIES

→ Oregon Health Authority, CCOs, and providers such as Federally Qualified Health Centers (FQHC) can help promote medical respite within Oregon's existing Medicaid flexibilities

1 CCO Opportunities through Medicaid Managed Care Flexibilities

- **Managed Care Request for Proposals (RFP):** Use program RFPs to establish CCO expectations during procurement process, including asking CCOs how they will address post-discharge needs for those experiencing homelessness
- **CCO Contracts:** Strengthen requirements for CCOs to work with medical respite providers, such as developing referral processes and contractual relationships, and requiring a designated point of contact such as NJ's requirement for managed care entities to have a housing specialist on staff
- **Strengthening SHARE Initiative Guidance:** Stronger, more prescriptive SHARE profit reinvestment requirements could mandate specific investments in housing-related services or medical respite care, such as requiring a set percentage of profits be designated for medical respite programs

2 Provider Opportunities

- **FQHCs:** FQHCs can operate medical respite care programs and receive reimbursement as part of their negotiated rate with the State Medicaid program and / or CCOs
  - FQHCs can partner with a shelter (FCHQ clinical staff enter shelter setting), or can operate their own recuperative care program (Central City Concern in Portland)
  - Oregon's Alternative Payment and Advanced Care Model per member per month (PMPM) wrap payments can promote delivery of non-traditional services like respite care
- **Other Medical Respite Providers:** Develop strong relationships with State Medicaid Agency and CCO staff to establish need for program and payment rates that cover all services being provided (particularly when providing clinical care and housing)
  - Strong evaluation of outcomes and benchmark goals can help encourage investment and collaboration with CCOs

Sources: NJ FamilyCare Managed Care Contract, NJ DHS. Medicaid & Medicaid Managed Care: Financing Approaches for Medical Respite Care, NIMRC. Health Centers Improve Health Outcomes with Medical Respite Care, NHCHC. Recuperative Care Program, Central City Concern. How Health Centers Can Improve Patient Care Through Value-Based Payment Models, CHCF.

PROMOTING MEDICAL RESPITE VIA EXISTING FLEXIBILITIES CAN ENCOURAGE GREATER CCO AND PROVIDER INVESTMENT BUT WILL NOT SUPPORT STATEWIDE ADOPTION

Opportunities of Promoting Medical Respite via Existing Flexibilities:

- ☑ Expansions via Managed Care RFP and stronger contract requirements do not take the resources of other pathways, which require CMS approval and authority (e.g., Section 1115 demonstrations)
- ☑ Reporting and evaluation requirements for HRS / SHARE investments are less burdensome than those of other pathways
- ☑ Can advance more quickly with upcoming CCO procurement
- ☑ Promotes stronger relationships between CCOs and homeless service providers that are critical for long-term efforts addressing chronic homelessness in Oregon

Limitations of Promoting Medical Respite via Existing Flexibilities:

- ☒ Cannot receive federal match for housing component of medical respite
- ☒ Not a statewide benefit
- ☒ Lack of consistency across CCOs (CCO provision of benefits is voluntary)
- ☒ Limited capacity of Shelter+ or Medical Respite Providers

State Pathways to Cover Medical Respite Care (New CMS Approval Required)

STATE APPROACHES TO PROVIDE MEDICAID REIMBURSEMENT FOR MEDICAL RESPITE VARY

→ States can use various approaches to pursue Medicaid reimbursement for medical respite services, some of which leverage federal match to pay for room and board and some using state-only funds to support the housing components of Medical Respite.

State Plan Amendment	Managed Care ILOS[1]	Section 1115 Demonstration
 **Minnesota.** Pursuing Medicaid reimbursement for Medical Respite via State Plan Amendments (SPAs) and daily bundled rates for recuperative care programs. Incorporating service definitions, benefits, and bundled rates into the provider manual. Room and board to be funded with state-only funds. This "braided funding" approach allows the state to cover *some* of the costs for Medical Respite through Medicaid. *Not seeking an 1115 Demonstration due to resources required.*	 **Nevada.** Incorporating Medical Respite into managed care as In-Lieu-of-Services (ILOS). Medical necessity is required, with a maximum of 90 days of benefit provided. Does not include infrastructure funds. Medical respite as ILOS *must* include provision of medical or behavioral health recuperative care; cannot be used to provide interim housing without additional care provision. *ILOS are provided at the discretion of the managed care plan (not a mandatory benefit).*	 **California.** Received statewide approval in CalAIM 1115 Demonstration for Managed Care Plans (MCPs) to optionally provide ***short-term post hospitalization housing*** for up to 6 months and ***recuperative care*** for up to 90 days. Services are for those experiencing homelessness or at risk of homelessness who need additional support to recover from an injury or illness following discharge. *Section 1115 Demonstration provides the only pathway for comprehensive, statewide authority for all components of medical respite, including room and board.*

State Level of Effort for Implementation

1. Existing CMS guidance on ILOS does not allow for payment of room and board, including recuperative care and short-term post-hospitalization housing. Nevada's pursuit of ILOS is pending CMS approval. Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule, CMS.

Sources: Status of State-Level Medicaid Benefits for Medical Respite Care, NIMRC. FY 2023-24 HHS Budget, MI Senate. A Proposal for Housing Supports as ILOS, Nevada. DHCFP Legislative Report: Medicaid-Reimbursable Recuperative Care, MN DHS. CalAIM Approval, Medicaid.gov.

STATES USE SECTION 1115 DEMONSTRATIONS TO EXPAND MEDICAL RESPITE BENEFITS STATEWIDE, WITH DIVERSE APPROACHES

→ Section 1115 Demonstrations are the primary vehicle for making Medical Respite a statewide Medicaid benefit. Yet, services, eligibility, and settings vary by state.

California *(Approved)*

Short-Term Post-Hospitalization Housing (STPPH): 6 months of *housing*, case management, and support for the ability to perform ADLs.

Recuperative Care: 90 days of residential care with ongoing *clinical support*.

Eligibility: Homeless or at risk of homelessness, and:

- *STPPH* – those exiting institutions with certain chronic conditions.
- *Recuperative Care* – requires need for on-going clinical care for healing.

Settings: Services provided in settings with on-site support, including health centers, group homes, and SNFs/ALFs.

Statewide expansion of county-led medical respite pilots started in 2015 under CA's Whole Person Care demonstration.

Kentucky *(Pending)*

Recuperative Care Pilot: Piloting 20 beds for up to 45 days. Includes housing, 24-hour staffing, clinical supports, on-site care coordination, and access to community behavioral health services.

Eligibility: Homeless or at risk of homelessness and are at risk of hospitalization and/or readmission. Requires a primary medical diagnosis.

Settings: Interim housing facilities, shelter beds, or other settings *with on-site support.*

Pilot program demonstration with limited bed capacity. Includes individuals with planned procedures or treatment needing housing in advance of treatment.

Limited to recuperative care with clinical support – no housing-only benefit.

Hawaii *(Pending)*

Services: Mirrors California's scope of services for STPPH and Recuperative Care.

Eligibility: Homeless or at risk of homelessness with at least one *health needs-based criteria,* including behavioral health need, substance use need, or complex physical health need.

Settings:

- *STPPH:* Wide array of housing facilities, shelter beds, providers of homeless services, supportive housing, etc.
- *Recuperative Care:* More limited settings with the requirement of *on-site support.*

Adopts many components of California's demonstration to speed approval process.

Planned delivery in coordination with 6 months rental assistance program.

Additional detail on each state's approach is found in the Appendix.
Sources: CalAIM Approval, Medicaid.gov. KY 1115 Waiver Application, KY.gov. HI QUEST Integration 2020 Approval, Medicaid.gov. HI QUEST Integration 2024 Renewal, Medicaid.gov

COMPARING STATE APPROACHES TO COVER MEDICAL RESPITE

	State Plan Amendment	Managed Care ILOS	Section 1115 Demonstration[1]
Federal match for provision of room and board		*Likely requires provision of clinical services; CMS approval of funding for room and board unclear.*	✓
State General Fund allocations required	✓		
Flexibility to pilot services in certain areas / populations		✓ *ILOS provided at discretion of CCO*	✓
Opportunity to leverage CMS HRSN Infrastructure funding			✓
Level of effort and CMS review or negotiations required	→		*Can be incorporated into 2028 1115 Renewal or as an Amendment*
Complexity of reporting requirements	→		*HRSN reporting requirements complex; can be incorporated into approach for rental assistance*
Key benefits	*Least level of CMS review and negotiations required*	*Enables CCO flexibility and innovation; can help strengthen relationships between CCO and shelter / recuperative care providers*	*Creates consistent and sustainable funding; Can leverage HRSN Infrastructure funding*

1. Additional considerations for pursuing a Section 1115 Demonstration to cover medical respite services are provided in the Appendix, Slide 20.

Moving Forward

ACTIONABLE SHORT- AND LONG-TERM APPROACHES TO SUPPORT MEDICAL RESPITE IN OREGON

Existing Medicaid Flexibilities

(Actionable in Short Time Frame)

- → Use CCO procurement (RFPs) and contracting requirements to incentivize and promote CCO investments in Medical Respite via SHARE initiative requirements and HRS spending on housing supports
- → Support service delivery expansion by FQHCs and other medical respite providers by compensating for the full continuum of care provided in these settings (e.g., FQHC value-based payments); include room and board fees within a larger bundled payment for delivery of clinical and behavioral health services

Requires Additional CMS Approval

(Actionable in Longer Time Frame)

- → **SPA:** Implement medical respite statewide using a braided funding approach; requires state general fund allocations and CMS approval of SPA.
- → **ILOS:** Make medical respite an optional ILOS for CCOs (requiring medical necessity/clinical care delivery). Inclusion of room and board pending CMS approval.[1]
- → **Section 1115 Demonstration:** Make medical respite a statewide benefit and optimize federal match for the provision of room and board.[2]

Near-term Planning Opportunity: OHA and other relevant state agencies may wish to engage with providers of homeless services and other organizations that currently offer medical respite services to ensure that their experience helps inform the expansion of medical respite services in Oregon.

1. Existing CMS guidance on ILOS does not allow for payment of room and board, including recuperative care and short-term post-hospitalization housing. Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule, CMS.
2. Can be accomplished through (1) an amendment to the existing waiver, or (2) inclusion in Oregon's 2028 1115 demonstration renewal request.

Appendix

PROVIDING VIA SECTION 1115 WILL ESTABLISH A STATEWIDE BENEFIT WITH FEDERAL MATCH BUT REQUIRES SIGNIFICANT INVESTMENT OF STATE RESOURCES AND BUY-IN FROM CCOS / PROVIDERS

Opportunities to Authorize Medical Respite via Section 1115 Demonstration:

- ☑ Can be used to establish a medical respite program that meets state needs that mandates CCOs provide and reimburse for services
- ☑ Creates more consistency in provision of the service across the state and provides a sustainable long-term source of funding
- ☑ Only opportunity to receive federal match for provision of room and board
- ☑ Can be used to pilot / test Medical Respite benefits for specific populations or pilot areas, if additional evidence is needed
- ☑ CMS is approving limited HRSN infrastructure funding dollars alongside the authorization of HRSN services to support states in helping providers make necessary IT upgrades, participate in Medicaid billing, etc.

Limitations of Authorizing Medical Respite via Section 1115 Demonstration:

- ☒ Significant investment of State time and other resources to draft, go through public comment, negotiate with CMS, and implement benefit *(with existing 1115, burden may be smaller as can be incorporated into 2028 renewal or as an amendment to current demonstration)*
- ☒ Complex and potentially time-consuming reporting requirements for housing supports provided under Section 1115 Authority
- ☒ Limited capacity of existing Shelter+ or Medical Respite Providers; infrastructure investments likely needed to support statewide uptake

ADDITIONAL DETAIL ON SECTION 1115 DEMONSTRATION APPROACHES

→ Section 1115 Demonstrations are the primary vehicle for making Medical Respite a statewide Medicaid benefit. Yet, services, eligibility, and settings vary by state.

State	Services	Eligibility	Settings
 **California (Approved)**	**Short-Term Post Hospitalization Housing (STPHH):** *6 months* of housing, case management support, and support for ability to perform ADLs (may include clinical and behavioral health services) **Recuperative Care:** *90 days* of short-term residential care with ongoing clinical support such as wound care, medication monitoring, short-term assistance with ADLs, and coordination of benefits	**STPHH**: Individuals exiting an institution (including recuperative care facility and inpatient hospital stay), with certain chronic physical or behavioral health conditions and/or those who are homeless or at risk of homelessness **Recuperative Care:** Individuals requiring on-going recovery to heal from injury or illness who meet HUD's definition of homeless or at-risk of homelessness	Facility types with appropriate clinical supports, such as health centers, wellness/respite centers, social service centers, skilled nursing facilities (SNFs), Assisted Living Facilities (ALFs), residential group homes, and community centers
 **Kentucky (Pending)**	**Recuperative Care Pilot:** Up to 20 beds at any given time for up to *45 days.* Services to include housing with 24-hour staffing, 3 meals a day, transportation, nursing assessment, medication monitoring, access to community behavioral health services, and care coordination (on-site).	Are homeless or at risk of homelessness and • Are at risk of hospitalization and/or readmission with medical need (following discharge from acute care facility or ED, have a planned procedure needing preparation care, OR have a planned medical treatment requiring care) • And, must have a primary medical diagnosis	Interim housing facilities with additional on-site support, separate units of shelter beds with additional on-site support, converted homes with on-site support
 **Hawaii (Pending)**	**Short-Term Post Hospitalization Housing (STPHH):** Mirrors CA's scope of services **Recuperative Care:** Mirrors CA's scope of services	Individuals must be homeless or at risk of homelessness, with at least one health needs-based criteria (behavioral health need, substance use need meeting ASAM level 2.1, or complex physical health need)	**STPPH:** (1) interim housing facilities; (2) shelter beds; (3) converted homes; (4) publicly operated or contracted recuperative care facilities; (5) supportive housing; (6) county agencies; (7) public hospital systems; (8) social service agencies; and (9) providers of homeless services. 1-4 must have additional on-site support. **Recuperative Care:** Provider types 1-4

Sources: CalAIM Approval, Medicaid.gov. KY 1115 Waiver Application, KY.gov. HI QUEST Integration 2020 Approval, Medicaid.gov. HI QUEST Integration 2024 Renewal, Medicaid.gov