MEDICAID REIMBURSEMENT FOR MEDICAL RESPITE SERVICES

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

POLICY ANALYSIS SEPTEMBER 2011

BACKGROUND

Individuals experiencing homelessness have disproportionate rates of acute and chronic illnesses, which drive high rates of hospital utilization. Lack of housing for this population complicates discharge planning and subsequent recovery, leading to high rates of hospital re-admission as well.[1] This utilization pattern has substantial cost implications for the health care system, which is compounded by high rates of uninsurance.

Nearly 65% of the 805,000 individuals receiving care at Health Care for the Homeless projects in 2010 were uninsured; however, in 2014, Medicaid will be expanded to cover most people who have incomes up to 133% of the Federal Poverty Level (FPL) as a result of the Affordable Care Act (ACA). This critical Medicaid expansion to low-income single adults will help most people experiencing homelessness access needed health services, to include prevention and disease management strategies.

Being insured does not necessarily reduce hospital utilization. In fact, a study based out of Canada, where health coverage is universal, found that people experiencing homelessness continued to experience longer inpatient stays and accrued significantly more in hospital costs than their housed counterparts.[2] Nationwide, the average hospital stay for most patients is 4.6 days, but those facing homelessness average a stay nearly twice as long.[3, 4] Longer inpatient stays and higher emergency room utilization is a consequence of inadequate housing.[5, 6] Whereas someone who is housed would normally be discharged to their home for rest and recuperation after a common procedure, people who are experiencing homelessness remain in the hospital or risk complications that are likely to arise from returning to the streets.

Though health coverage is a tremendous step toward improving health care, innovative models of delivering care will be needed to reduce costly and avoidable hospitalizations and re-admissions by people who are experiencing homelessness. States have significant flexibility to implement models of care that will improve health outcomes and minimize costs. A number of reports and analyses have been published on models of care such as health homes, home and community-based service models, chronic disease prevention programs, and permanent supportive housing. This analysis describes medical respite care as an innovative model of care that reduces hospitalizations, and details state policy options for receiving federal Medicaid funding to support this service.

Introduction

Medical Respite Care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. Medical respite programs allow homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. It is offered in a variety of settings including freestanding facilities, homeless shelters, nursing homes, and transitional housing.

Medical respite programs did not formally arise in the United States until the 1980s. Until the 1930s, people who were sick and without housing received care in poor houses or infirmaries. These institutions were usually bleak and shared with others living in poverty and suffering from mental illness, addiction, and/or disability.[7]

In the 1930s, after the Great Depression, the perception of homelessness shifted from being seen as an inherent personal deficit to being a consequence of systemic failures. As such, new federal programs were established to provide emergency housing. People in need of a bed for recuperation were dependent on day-time access to these shelters or forced to recuperate on the street. This continues to be the case in most communities where medical respite programs are not available.

The first contemporary medical respite programs began in Boston and Washington, D.C. in 1985. A statement written in 1983 by Dr. Janelle Goetcheus, founder of the Christ House in Washington D.C., describes the impetus for this new model of care:

> "This winter, a 74-year old man came to the Health Service on a very cold day. He was living on the street. Never to be forgotten is the sight of his sitting on a chair humped over with his wet coat pulled up over his head trying to get warm. He had no shirt under the wet coat – only bare cold skin. His trousers and shoes were soaked. He had no socks. The entire day was spent making phone calls trying to locate a place for him to return to—other than to the men's shelter. An attempt was also made to locate a Medicare number for him in order that he could be admitted to the hospital. Consideration was given to just sending him to the emergency room. However, when similar men had been sent to emergency rooms in the past, they were just discharged—often late at night—with no place to go, and with the shelter filled by that time.
>
> He stayed at the Health Service all day. He ate and was given clean clothes. After it was not possible to locate any other place for him to stay or his Medicare number, he left to go back to the men's shelter. He was to return to the Health Service the next day to continue this search and the application process. But he was found frozen to death in a phone booth, on the streets of Washington, DC. The official cause of death was hypothermia. No alcohol was noted in his blood."[8]

Such circumstances are not uncommon for people experiencing homelessness. During the 1980s, drastic reductions to housing and other federal programs caused homelessness to increase substantially, leaving health care providers struggling to meet the unique health care needs posed by people living in shelters and on the street. Unfortunately, these conditions persist today, compounded by further budget reductions to public housing and other safety net programs, and costs related to housing and health care that have not kept pace with average wages. Hence, medical respite care services are increasingly needed as health care systems struggle to identify cost-saving measures related to reducing lengths of stay and hospital re-admission.

Services Provided by Medical Respite Programs

Medical respite programs fill a gap in the continuum of care for people who are experiencing homelessness. Generally, people are discharged from a hospital within a day or two of being treated, with instructions to rest, eat well, and complete a course of medication or other treatment until fully recuperated. Unless hospitals choose to extend inpatient stays (which has cost implications), people who are without housing must attempt to follow instructions while living on the street.

Recuperation on the street is nearly impossible. Local laws that criminalize homelessness prevent people from sitting or lying down in public. Unsanitary conditions cause open wounds to become infected, clean bandages quickly become filthy, washing facilities are generally unavailable, medication requiring refrigeration is compromised, and prescribed diets are not available. As a result, health complications arise and patients are

often readmitted to hospitals for complications that would have been avoidable had the individual a home or safe and clean place for recuperation.

Medical respite programs were established to fill this void in the delivery of health care services. Most patients seen in the medical respite setting are referred by hospitals or other community health care providers. Post-acute medical care is delivered by physicians, physician assistants, nurse practitioners, and nurses who may be onsite 24-hours a day or during set hours. Though the length of stay varies depending on the medical condition, the average length of stay in a medical respite program is 2 weeks to a month. During this time, patients are provided with strict medical oversight and offered an array of services aimed at improving health. Services such as patient education around acute and chronic disease management are core to medical respite programs. Providers use a number of techniques to maximize the efficacy of patient education such as motivational interviewing and self-management goal setting. Providers also work with program participants to help them better navigate the health care system. Patients are linked to a primary care provider and are counseled on when to visit their primary care provider and when to go to the emergency department. In addition to patient education and connection to a primary care provider, medical respite providers link patients to any needed behavioral health services and help coordinate care among multiple providers.

Support services are also an essential component of medical respite programs. Nurses, social workers, case managers, or community health workers[9] assist patients with benefits and entitlements, housing applications, and therapeutic counseling aimed to help patients maintain stability once they complete the medical respite program (see figure 1 for a list of services provided at medical respite programs).

FIGURE 1. Services Provided at Medical Respite Programs

ACUTE AND POST-ACUTE CLINICAL SERVICES PROVIDED AT MEDICAL RESPITE PROGRAMS	SUPPORT SERVICES PROVIDED AT MEDICAL RESPITE PROGRAMS
▪ Wound care and infection control	▪ Benefit and entitlement acquisition
▪ Pain management	▪ Case management
▪ Ambulation/physical therapy	▪ Transportation
▪ Medication monitoring	▪ Housing applications
▪ Patient education (disease management and prevention)	▪ Linkage to appropriate behavioral health services if needed
▪ Ongoing assessments and monitoring	▪ Care coordination
▪ Development of disease management action plans/goal setting	▪ Connection to a primary care provider/medical home
▪ Discharge planning	▪ Patient navigation
	▪ Counseling

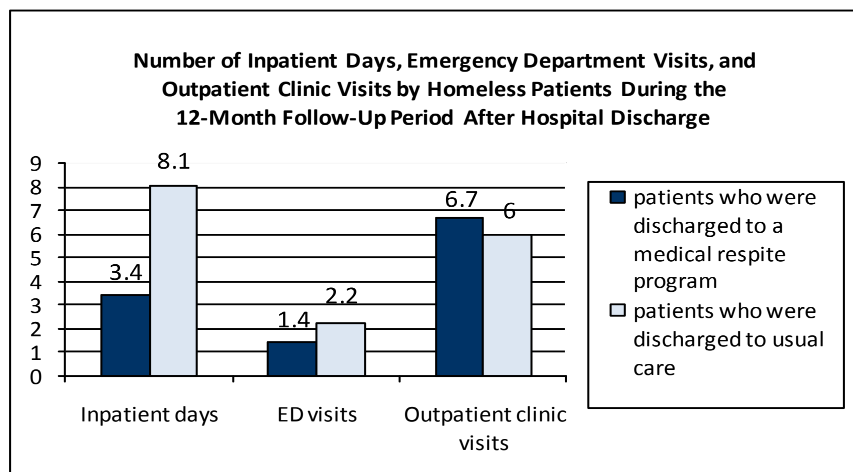
Academic literature and cost findings

Academic literature is robust when describing the health needs of people experiencing homelessness; however, very few studies have been published describing medical respite programs, particularly with regard to costs. Of the several studies published, two academic articles provide a promising evidence-base for medical respite programs.

The first empirical study looking at the effects of medical respite care for homeless patients was published in 2006. The study, conducted between 1998 and 2000, looked at the impact on inpatient days, emergency department visits, and outpatient clinics for patients of an urban public hospital. Patients were separated into two groups: patients referred and accepted into the medical respite program and patients referred but denied beds due to capacity issues. During the 12-months of follow up, the group that used medical respite services required fewer hospital days (3.4 vs. 8.1 days). Though the study found a reduction in emergency department utilization and an increase in outpatient clinic visits by the medical respite group, the findings were not statistically significant (see figure 2).[10]

The second study, published in 2009, examined whether post-hospital discharge to a medical respite program was associated with a reduced chance of a 90-day readmission compared to other disposition options. Conducted in Boston between 1998 and 2001, this study found that discharge to a medical respite program was associated with a 50% reduction in the odds of readmission at 90 days post-discharge compared to discharge to the streets and shelters.[11]

Figure 2. Changes in Hospital Utilization based on Participation in Medical Respite



Source: Buchanan, D., Doblin, B., Sai, T., & Garcia, P. (2006). The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health, 96*(7), 1278–1281.

Several communities have conducted their own analysis to help guide decisions to invest in medical respite care. For example, Oregon Health & Science University found that they averted $3.5 million in costs over three years by investing $500,000 in a local medical respite program.[12] CareOregon, a local HMO, now reimburses up to a 30-day stay in the medical respite program for eligible members at a daily rate of approximately $115.

Current Financing

Of the 57 programs operating in the United States, most use a patchwork of local grants and other one-time-only funding to sustain both the residential and health services, but others are able to draw down federal reimbursement through a variety of mechanisms this analysis seeks to clarify and promote (see Table 1).

The significant disadvantage to local grants and other non-federal funding is their tenuousness, making long-term services and program development more difficult. Several programs, primarily those affiliated with a

federally qualified health center, are able to bill Medicaid and Medicare for medical respite care. Medicaid reimbursement brings financial stability to medical respite programs and increases the capacity of programs to serve more people. Reimbursement also permits practitioners to bill for their services, allowing other revenues to be used to support the residential and supportive components of medical respite programs.

Medical respite programs also benefit from support from the U.S. Department of Housing and Urban Development (HUD) and HRSA in order to cover the cost of both the beds and provision of care. These funding streams are administered separately, with discrete program and reporting requirements. In 2010, HUD and HRSA formed a working group called, "Expanding Medical Respite Care for Homeless Individuals with Complex Health Care Needs" as part of President Obama's request for federal agencies to work collaboratively to address poverty in the United States. The group was established to discuss opportunities to combine support for medical respite programs. As of this publication, the working group has not released recommendations.

The U.S. Interagency Council on Homelessness (USICH), an independent agency within the federal executive branch composed of the heads of 19 departments and agencies, included medical respite care as a strategy in its federal plan to prevent and end homelessness.[13] The USICH is helping to facilitate conversations and coordinate efforts among the various agencies to promote and support medical respite care.

Table 1. Financing of Existing Medicaid Respite Programs

TYPE OF FINANCING USED	NUMBER OF RESPITE PROGRAMS
Hospital support	27
Local government	25
Private donations	22
Foundations	21
Option for Health Center funds	17
Religious organizations	14
HUD	13
United Way	11
Medicaid/Medicare reimbursement	8

Source: National Health Care for the Homeless Council. 2011 Medical Respite Program Directory
Note: May not add to 60 due to multiple financing arrangements used at some projects.
Information is based on data collected from medical respite programs annually and is subject to change.

State Options for Financing Medical Respite Care through Medicaid

States have considerable flexibility in using their Medicaid plans to support medical respite care. The most common avenue for drawing down federal funds for medical respite services is through the federal Health Center program. Other options for a federal match are through a Section 1115 Demonstration waiver or through the Home and Community Based Services Program.

➔ Reimbursement through the Federal Health Center Program

Federally Qualified Health Centers (FQHCs), authorized under Section 330 of the Public Health Services Act, provide outpatient primary care services to underserved and uninsured individuals regardless of their ability to

pay. In addition to primary care, other services provided by FQHCs include treatment for mental illness, case management, and enabling services such as outreach, transportation, and translation services.

In 2003, recuperative care (synonymous with medical respite care) was added to the Health Center statute as an additional service that FQHCs could include within their scope of project, enabling them to use their federal funding to provide this service. [14] Though not in statute, the Health Resources and Services Administration (HRSA), which oversees the Health Center program, uses the following definition for recuperative care:

> *Recuperative care is defined as short-term medical care and case management provided to persons (generally homeless) recovering from an acute illness or injury, whose conditions would be exacerbated by living on the street, in a shelter or other unsuitable places. This unique set of clinical and non-clinical services, often referred to as a recuperative care program, is offered to treat patients with conditions that have an identifiable endpoint of care for discharge from a facility/setting designed for such purpose.*[15]

Health Centers receive certain federal benefits for providing services to uninsured and underserved patients. These benefits include the ability to use federal health center dollars for services, ability to receive Medicaid reimbursement, and federal liability coverage. In order to receive these benefits for the provision of medical respite care, the health center grantee must submit an application to HRSA requesting to include medical respite care within its Scope of Project.

Before approving a change in scope request, HRSA will consider whether the request furthers the mission of the health center by increasing or maintaining access, and improving or maintaining the quality of care for the target population. Requests cannot result a reduction in the level or quality of health services currently provided to the target population. In addition, health centers wishing to provide medical respite services cannot shift resources away from other services within its Scope of Project for the targeted population and must be able to provide the service without additional health center funding.

In order to receive Medicaid reimbursement under the FQHC per-visit payment system for medical respite services provided to patients who are Medicaid-eligible, the FQHC must submit a request to their state Medicaid agency to change the Scope of Services covered under these payments. The state Medicaid agency must review and approve this change request. During the agency's review, it may reexamine the per-visit rate paid to the FQHC (which is determined using either the Prospective Payment System (PPS) or Alternative Payment Mechanism APM.) If the per-visit costs associated with medical respite care services are significantly different from the existing per-visit payment rates, the Medicaid agency may adjust the rates to reflect these costs.

Most health centers do not have the resources to provide both the residential and the medical services on their own. Moreover, health center funds cannot be used to support the cost of room and board for the program. As such, many communities have established innovative partnerships in order to provide medical respite care. The simplest approach usually involves partnering with a local shelter that provides 24-hour residential services and security; health centers then agree to have a clinician on site during set hours in which each contact with a Medicaid beneficiary is a billable encounter as an FQHC service.

Allowing FQHCs to bill Medicaid for medical respite services furthers the mission of the federal health center program, which is to provide comprehensive, culturally competent, quality primary health care services to

medically underserved communities and vulnerable populations. However, as of this publication, health centers only operate a third of medical respite programs. The next two options described in this analysis can benefit both health centers as well as non-FQHC medical respite programs.

➔ Section 1115 Waiver

Section 1115 of the Social Security Act allows states to request a waiver to bypass certain health and welfare provisions of the Act in order to conduct research and demonstration projects. To date, 30 states and the District of Columbia have used Section 1115 waivers to waive federal Medicaid requirements. This waiver is generally used by states to expand eligibility, test service delivery and payment models, or limit or expand certain services. All waiver requests must meet the objectives of the federal Medicaid program.

States using the Section 1115 waiver need to make the case for "budget neutrality," meaning the federal government would not be spending more than it would absent the waiver. In order to enforce budget neutrality, the federal government may place a cap on the amount of federal dollars that can be used for the demonstration. The cap may be one aggregate sum that can be used for the entire demonstration or it may be a per capita cap, an amount that can be spent per beneficiary for the service. The issue of budget neutrality can be easily demonstrated by comparing the cost of medical respite care to the cost of an extended hospital inpatient stay; on average, the cost of medical respite is 10% of the cost of a hospital stay.[16]

A Section 1115 waiver can be used to waive any number of Medicaid requirements in order to carry out a demonstration program. This analysis describes four options for states to consider when proposing a medical respite demonstration program using the Section 1115 waiver.

First, states can use the waiver to expand eligibility to targeted populations. While the Affordable Care Act requires states to expand Medicaid in 2014 to single individuals with incomes up to 133% of the Federal Poverty Level (FPL) and receive an enhanced federal match, a waiver could be used to expand eligibility ahead of 2014 based on specific criteria (such as housing status). States would receive their usual federal match prior to 2014. This allows budget-strapped states to expand more incrementally to targeted populations who, if insured, would likely participate in preventive and routine outpatient services and reduce their use of more costly emergency and inpatient services over time.

Second, a Section 1115 waiver can also be used to waive "statewideness." When states expand Medicaid eligibility and services, they are generally required to implement the expansion across the entire state, but a waiver allows a state to expand to specific geographic areas instead. By targeting specific geographic areas (usually counties), states have better control and oversight of the demonstration project and may be able to compare cost and outcome data with non-demonstration counties for evaluation purposes. Waiving "statewideness" can also help a state incrementally expand health services through Medicaid and focus on high-needs areas (such as urban areas that have a high rate of homelessness).

Third, states may also use the 1115 waiver to expand reimbursable services to include medical respite care. Demonstration projects that include medical respite care should examine any adjustments needed to state or federal provisions that limit reimbursable services to certain providers and facilities. For example, services provided by nurses, who are often employed by medical respite programs, are generally not reimbursable through Medicaid. An 1115 waiver request may need to include language regarding the package of medical respite services that would be reimbursed and the providers authorized to provide medical respite services.

Language may also need to address acceptable facilities for the provision of services because most medical respite programs are not based in licensed medical facilities. In all, a demonstration proposal sent to the Centers for Medicare and Medicaid Services (CMS) will need to address the following components: environment, administration, eligibility, coverage and benefits, delivery system, access, quality, financing issues, systems support, implementation time frames, and evaluation and reporting.

Fourth, states may choose to use the 1115 waiver to provide reimbursement to hospitals for payments made to a medical respite program that admits a hospital patient. Depending on the health care delivery system and payment model, this alternative may be easier to implement and may create less administrative burden. In this arrangement, reimbursements are only received for beneficiaries referred from hospitals and not for patients who are referred by other homeless service providers. An unintended consequence may be an interruption in hospital diversion programs that may be in place. Hospital diversion programs attempt to reduce hospital visits by redirecting individuals to medical respite programs instead of the hospital when appropriate. In communities with hospital diversion programs in place, medical respite programs accept referrals from a variety of health care and social service agencies. If reimbursement were only available through hospital referrals, medical respite programs may elect to limit referrals from less costly health care and social service providers as it would be to the advantage of the medical respite program to send patients to the hospital first.

These four options offer state flexibility to tailor expansion of medical respite services to specific populations, geographic areas, and/or provider types. Together, they offer an opportunity to implement medical respite as part of a demonstration project in a local community.

➔ Home and Community-based Services

Section 1915 of the Social Security Act includes several Home and Community-based Service (HCBS) programs tailored to meet the personal care and home health needs of certain populations. All states and the District of Columbia have one or more Medicaid Home and Community-based Services programs in place. As a cost control mechanism, most states have instituted more restrictive eligibility standards than what the federal program requires.[17]

HCBS programs are most well-known as methods to keep seniors and individuals with disabilities out of institutional care by extending their ability to remain in the community [generally through Section 1915(c) programs]. Traditionally to be eligible, beneficiaries would need to have a functional needs assessment conducted by a contracted provider, usually the local Department of Health and Human Services, the Area Agency on Aging and Disability, or an Aging and Disability Resource Center. Medical respite programs generally limit scope of care to acute and post-acute needs and are not set up to manage long-term functional impairments.

However, the 1915(i) HCBS program, added to the Social Security Act in 2005 as a deficit reduction measure, permits states to provide low-income individuals with services and supports before they need institutional care. The program also provides states with a mechanism to offer HCBS to individuals with mental health and substance use disorders. Though people with acute and post-acute medical needs may not qualify for the traditional HCBS program, the 1915(i) HCBS program is much more flexible and therefore, likely to be a more feasible option to pursue for the purposes of funding medical respite services.

The Affordable Care Act (ACA) improved the 1915(i) program by allowing states to target particular groups of people. In a letter to State Medicaid Directors, CMS gives an example of a state proposing to have one 1915(i) program package targeted to persons with physical and/or developmental disabilities, and another 1915(i) program package targeted to persons with chronic mental illness.[18] People who are experiencing homelessness and in need of medical respite care would be an appropriate targeted beneficiary group. States can also design service packages without regard to "comparability" meaning the service package can be different in amount, duration, or scope for different population groups. For example, one service package could include only medical respite services for people who are experiencing homelessness and at risk of inpatient hospitalization while a completely different service package is available for another targeted group. Any services other than the traditional HCBS services (case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, caregiver respite care) will need to be included in the state plan amendment and approved by the Secretary of Health and Human Services. Services cannot include room and board and must be budget neutral.

The ACA also allows states to create a new Medicaid eligibility criterion based on the states 1915(i) program. For example, a state that chooses to target people who are experiencing homelessness and at risk of inpatient hospitalization, could create a new Medicaid eligibility category for that group which would ensure access to HCBS to individuals who are not yet requiring institutional level care and are as-yet ineligible for the Medicaid program.

Conclusion

Medical respite care is an innovative solution to inappropriate hospital discharges and frequent emergency department/hospital utilization by individuals experiencing homelessness. Using this policy analysis, policy makers can better support this model of care within the existing health care framework.

Policy makers may need to establish program models to fit within the existing health care system. Medicaid reimbursement for FQHC services is a reimbursement mechanism that fits within the existing Medicaid framework. However, of the 57 existing programs, only a third are operated by an FQHC. For non-FQHC programs, policy makers may need to tailor state Medicaid programs by requesting an 1115 demonstration waiver or a 1915(i) state plan amendment to include targeted home and community-based services.

While the federal Medicaid program offers several options to finance medical respite care, states may also elect to finance medical respite services without federal assistance because of the cost savings possible through reduced hospital readmissions. Such is the case in California where a managed care organization (MCO) reimburses hospitals for the cost of sending a patient to a medical respite program. In addition to averting costs associated with length of stay, by reimbursing medical respite care, the MCO will minimize the prospect of post-discharge complications and readmissions arising from living on the streets while ensuring that the patient has adequate supports to assist greater life stability.

Recommendations

The following recommendations are intended to stimulate discussions and partnerships, and serve to provide specific legal mechanisms to create and sustain medical respite programs in local communities where there is a need for them.

➔ For providers

- Be able to demonstrate the need to establish or sustain a medical respite program in your community. Collect both quantitative (e.g., average cost of hospitalizations/ED visit v. cost of a respite program; point in time homeless census information, etc.) and qualitative data (e.g., interviews with consumers and providers at hospitals, health centers, and shelters)
- Meet with your local Homeless Commission or Coalition and/or your local Continuum of Care to gain support for a medical respite program. Present local data, empirical research, and describe medical respite as a strategy promoted in the Federal Strategic Plan to Prevent and End Homelessness.
- Build support by engaging local hospital administrators and state health officials (especially those from the Medicaid office). Schedule meetings for discussion and tours of health centers and other areas where individuals needing medical respite currently receive services.
- Be diligent and patient. Your State Medicaid Agency is responsible for submitting requests to CMS. Convincing decision makers to submit or amend an existing 1115 demonstration waiver or implement a state option will require patience and diligence. What's more, some states require legislative action before proposals to change the State Medicaid plan can be sent to CMS.
- Meet with State and local policy makers. Educate them about homelessness and the challenges involved with discharge planning, hospital utilization, and cost implications.

➔ For local and state policy makers

- Meet with local homeless health care providers to better understand issues related to homelessness, costs of health services for this population, and other operational challenges related to state health policy. Determine if any policies act as a barrier for medical respite programs to be fully integrated in the state health care delivery system and take action to eliminate those barriers.
- If appropriate, meet with administrators of state Managed Care Organizations to discuss the advantages of including medical respite care as a benefit for Medicaid beneficiaries who are experiencing homelessness.
- Conduct a cost-analysis related to individuals experiencing homelessness and the value of medical respite care to establish the merits of pursuing a Medicaid demonstration or HCBS option.
- Include medical respite in the plans to implement the Affordable Care Act. Large hospitals contracting with insurers participating in state exchanges will be required to have adequate discharge transition plans in place for patients; medical respite helps achieve that goal.[19]

➔ For federal policy makers

- CMS should issue a "*Dear State Medicaid Director*" letter to encourage states to use existing state options under Medicaid to support medical respite programs.

- HRSA should provide Service Expansion and New Access Point funding opportunities for Health Centers that expressly encourage medical respite services, and consider using capital funds available from the ACA to help finance capital expenditures.
- HUD and HHS (through HRSA) should collaborate on comprehensive and stable funding for medical respite programs that addresses the need for residential and services funds to be used together.
- Medical respite care should be included in key health reform initiatives targeting vulnerable and underserved populations. Such initiatives include patient-centered health homes, shared savings through Accountable Care Organizations, comprehensive hospital discharge programs, and state plan amendments to expand Home and Community Based Services.

Medical respite programs offer a cost efficient solution to improve medical care for people who are experiencing homelessness while reducing avoidable hospital utilization. As of the writing of this paper, only 57 programs are available to the nearly 1.6 million people who experience homelessness annually.[20] Sustainable funding options are needed if medical respite programs are to become more widely accessible for the people who need them.

Notes

[1] Salit, S.A., Kuhn, E.M., Hartz, A.J., Vu, J.M., and Mosso, A.L. (1998.) Hospitalization costs associated with homelessness in New York City. *New England Journal of Medicine,* 338(24): 1734-40.
[2] Hwang, S.W., Weaver, J., Aubry, T., and Hoch, J.S. (April 2011.) Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services. *Medical Care,* 49(4): 350-354.
[3] Agency for Healthcare Research and Quality. (2008). National and regional estimates on hospital use for all patients from the HCUP Nationwide Inpatient Sample (NIS). Accessed April 8, 2011 at: http://hcupnet.ahrq.gov/HCUPnet.jsp.
[4] Ibid: 1.
[5] Ibid.
[6] Ibid: 2.
[7] Shackman, G. (2008). The County Poor House. *The Ann Arbor Observer: Then and Now.* Available at: http://aaobserver.aadl.org/aaobserver/13033.
[8] Christ House. About Christ House. Available at: http://christhouse.org/about/index.html.
[9] National Health Care for the Homeless Council. (2011). Community Health Workers in Health Care for the Homeless. Available at: www.nhchc.org/Publications/CHWguide.pdf
[10] Ibid: 11.
[11] Ibid: 10.
[12] Beghtel, D. (March 23, 2009). Portland's post-hospital care for homeless falls short of meeting needs. *The Oregonian.* Available at: http://www.nhchc.org/Respite/respitemediaarchive/PortlandMarch09.pdf.
[13] U.S. Interagency Council on Homelessness. (June 2010). *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.* Washington, DC: 45. Available at: http://www.usich.gov/opening_doors/.
[14] Public Health Service Act, Section 330(b)(2).
[15] Health Resources and Services Administration. Health Center Expanded Services Supplemental Funding Instructions. Available at: http://www.hrsa.gov/grants/apply/assistance/ExpandedServices/announcementandinstructions.pdf.
[16] National Health Care for the Homeless Council. (2011). Medical Respite Care: Reducing Costs and Improving Care. Available at: http://www.nhchc.org/Respite/RespiteCostFinal.pdf
[17] Kaiser Commission on Medicaid and the Uninsured. (2011). Medicaid Home and Community-based Service Programs: Data Update. Available at: http://www.kff.org/medicaid/upload/7720-04.pdf
[18] The U.S. Depart of Health and Human Services. Centers for Medicare and Medicaid Services. (August 6, 2010). Dear State Medicaid Director Letter. Improving Access to Home and Community-Based Services. Available at: http://www.cms.gov/smdl/downloads/SMD10015.pdf
[19] Patient Protection and Affordable Care Act, Section 1311(h)(1)(A)(ii).
[20] The U.S. Department of Housing and Urban Development reported over 1.59 million people experiencing homelessness in 2010. This figure is a conservative estimate as it excludes individuals who avoided the shelter system, used only privately funded shelters that are not part of the HUD's continuum of care, and who are doubled up with friends and families in order to avoid the streets and shelter.http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf