DEPARTMENT OF HUMAN SERVICES

Legislative Report

Medicaid-Reimbursable Recuperative Care

Benefits to Support People Without Homes in Need of Short-Term Recuperative Care

Prepared by Health Management Associates for the Department of Human Services, Health Care Administration

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $160,000.

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I. Executive Summary

In the 2021 Legislative session, the Minnesota Legislature and Governor Walz enacted H.F. 2128 section 23, which directed the Minnesota Department of Human Services (DHS) to develop a Medicaid-reimbursable Recuperative Care service to serve people experiencing homelessness either after they are discharged from a hospital stay or to treat an acute condition to prevent the need for a hospital stay or another higher level of care. Recuperative care (also known as medical respite care) is an effective and evidence supported[1] strategy to help people experiencing homelessness by providing medical care that prevents either admission or readmission to more intensive hospital or nursing facility care.

In response to the Governor's and Minnesota Legislature's direction, DHS contracted with Health Management Associates (HMA), a nationally recognized consulting company focused on the public payer healthcare environment, to engage with stakeholders and develop this report in cooperation with Health Care Administration staff. From June through October 2022, HMA and DHS staff met with a diverse group of stakeholders including health care systems, managed care organizations, DHS representatives from Behavioral Health and other divisions, shelters for unhoused individuals, and people with lived experience of homelessness who had benefited from existing recuperative care programs in Minnesota. HMA staff included former state Medicaid and Behavioral Health Directors as well as experts in recuperative care program management and stakeholder engagement.

HMA presented summaries of other state approaches to Medicaid support for behavioral health from states as diverse as Utah, Washington, New York, and California informed by models, frameworks, and standards established by the National Institute for Medical Respite Care. Over a series of 7 stakeholder meetings, regular check-ins with DHS, and interviews with representatives of existing Minnesota recuperative care programs, HMA developed a set of recommendations designed to leverage existing state resources and capabilities and to address the needs of Minnesotans in need of medical care while they are homeless.

The recommendations include options for Medicaid support for consideration by the Minnesota Legislature described below. These options are presented in order of complexity and resource need for support.

1. Support for technical assistance through DHS' Medicaid program to assist recuperative care programs with navigating the Medicaid system of care, including provider enrollment, credentialing, billing, and complying with Minnesota and federal requirements for Medicaid providers. This would be helpful for supporting any of the higher numbered options listed below and a must for more complex options.
2. Establishment of care coordination benefits specific to recuperative care programs to ensure that people receiving services have access to appropriate medical, behavioral health, and social services

[1] See "Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care", National Institute for Medical Respite Care, March 2021

while they are convalescing and connecting them with resources to support them in gaining stable housing once they are well enough to be discharged from recuperative care.

3. Establishment of a daily bundled payment method to simplify billing and administrative requirements and comprehensively support recuperative care programs for the Medicaid benefits they can provide, including admission and discharge criteria appropriate for use of Medicaid funding informed by the needs of existing programs and the desire to promote new options
4. Support for room and board and other expenses not ordinarily allowed under Medicaid coverage by designating state-only funding streams to complement Medicaid support strategies
5. Support for longer-term strategies for payment of room and board expenses not ordinarily covered by Medicaid through an 1115 demonstration waiver request to the federal government.

The 1115 demonstration waiver request option should be considered in coordination with other state activities that would more broadly address social drivers of health for the Medicaid population. Demonstration waivers require a significant amount of administrative resources and based on other states, CMS has only moved forward with proposals that address social drivers of health on multiple fronts.

II. Legislation

This report is based on Laws of Minnesota 2021, Chapter 30, Article 1, Section 23:

Sec. 23. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; FUNDING FOR RECUPERATIVE CARE.**

The commissioner of human services shall develop a medical assistance reimbursable recuperative care service, not limited to a health home model, designed to serve individuals with chronic conditions, as defined in United States Code, title 42, section 1396w-4(h), who also lack a permanent place of residence at the time of discharge from an emergency department or hospital in order to prevent a return to the emergency department, readmittance to the hospital, or hospitalization. This section is contingent on the receipt of nonstate funding to the commissioner of human services for this purpose as permitted by Minnesota Statutes, section 256.01, subdivision 25.

III. Introduction

The Minnesota Legislature directed the Minnesota Department of Human Services (DHS) to develop a Medicaid-reimbursable Recuperative Care service designed to serve individuals with chronic conditions who lack a permanent place of residence at the time of discharge from a hospital or emergency department. Recuperative Care, also known as Medical Respite, is an effective evidence-supported way to keep people experiencing homelessness out of hospitals as a step-up level of care and to provide a safe space for recovery and healing.

Medicaid-Reimbursable Recuperative Care Service

This report is submitted to the Minnesota Legislature pursuant to Laws of Minnesota 2021, Chapter 30, Article 1, Section 23. The DHS Purchasing and Service Delivery Division contracted with Health Management Associates to provide expert research and guidance, and to solicit and incorporate stakeholder input into the development of the recommendations. Health Management Associates conducted research on Recuperative Care Programs, potential avenues for including Recuperative Care as a Medicaid benefit in Minnesota, solicited input from key stakeholders, and provided expert consultation throughout the process.

Stakeholder Engagement

Stakeholders and Stakeholder Meetings

Forty-four organizations were invited to participate in a series of seven stakeholder meetings from July through October. During these meetings, information on elements of Recuperative Care Programs, examples of Recuperative Care Programs in other states, and options for adding Recuperative Care to the Minnesota Medicaid benefit was presented and discussed.

Key Informant Interviews and Meetings

Individual meetings and interviews were conducted with key stakeholders to gain insight, background, and perspectives. Such interviews and meetings were held with the following organizations and groups:

- People currently receiving medical respite or having recently received medical respite through Higher Ground in St. Paul, MN.
- Bob Tavani House
- Bloomington Public Health
- Catholic Charities
- Healthcare for the Homeless
- Hennepin Health
- Minnesota Association of Community Health Centers
- Minnesota Council of Health Plans
- Minnesota Interagency Council on Homelessness

- Minnesota Tribal Collaborative
- Minnesota Association of Resources for Recovery and Chemical Health
- Minnesota Housing Finance Administration

IV. Research and Analysis

State Medicaid programs and overall approaches to supporting recuperative care benefits were researched. Sources for research included the National Institute for Medical Respite Care (NIMRC), federal Medicaid program records for Medicaid state plan[2] and waiver authorizations for recuperative care benefits and related services, other states' reports and information related to their recuperative care benefits, and additional resources from managed care plans and other organizations involved with supporting or studying Medicaid recuperative care approaches. NIMRC resources proved especially useful and HMA met with Director of Programs and Services Julia Dobbins as we conducted our research.

In addition to reviewing these existing programs and approaches, HMA drew on Medicaid program expertise and conducted a review of available funding authorities that have or could be adapted to support a recuperative care program. This was accomplished by drawing on statutory boundaries in the Social Security Act, the Code of Federal Regulations, and sub-regulatory guidance and informational resources provided by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services.

Existing recuperative care programs and services for people experiencing homelessness in Minnesota were also highlighted. This aspect of the research overlapped with stakeholder outreach efforts described above as HMA interviewed and met with representatives from shelters and health care providers serving people without homes as well as state agency staff involved with efforts to address the problem of homelessness within the states. Minnesota's established Recuperative Care Programs were also invited to share an organizational overview with all stakeholders.

Common Recuperative Care Program Elements

NIMRC recently published a helpful framework for understanding Models of Medical Respite Care which outlines key components for all models of recuperative care as well as describing four different models for care based on services and supports provided under the recuperative care program. Key components of recuperative care programs include[3]:

- 24 hour access to a bed
- 3 meals a day
- Transportation to medical appointments
- Access to a telephone for telehealth and communications related to medical needs

[2] The Medicaid state plan can be thought of as the contract between a state and the federal government to operate a Medicaid program and is a foundational document for each state Medicaid agency.

[3] National Institute for Medical Respite Care

- A safe space to store personal items
- Wellness check at least once every 24 hours by clinical or non-clinical medical respite staff

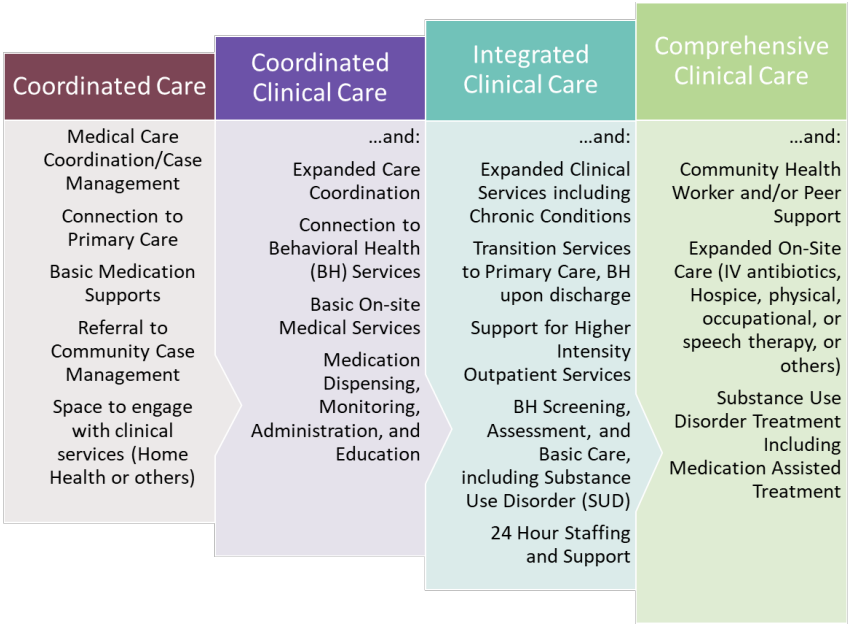
NIMRC's description of the four models of care is summarized in Figure 2. Stakeholders agreed that programs operating in Minnesota today were described by the coordinated care model, but that adding services to allow for a coordinated clinical care model was desirable. In terms of services that are commonly funded by Medicaid**, care coordination or case management for efficient connection to medical services and basic nursing care** are foundational for any recuperative care support approach.

Recuperative Care Programs in Other States

Eleven states (AZ, CA, DC, MA, MD, MI, NY, NV, OR, TN, and WA) use some form of Medicaid funding to support their recuperative care program[4]. Many of those programs use existing Medicaid benefits as they stand rather than benefits specifically structured to support recuperative care. California, New Mexico, New York, and Utah are either preparing or have submitted requests for recuperative care support (including room and board supports not ordinarily available through Medicaid) under an 1115 demonstration waiver, which allows for greater flexibility in design, funding, and implementation of Medicaid benefits to innovate and explore new and better approaches to care for Medicaid beneficiaries. California's waiver was approved in June of 2022 and implementation is beginning.

Numerous individual shelter- or clinic-based programs leverage either Federally Qualified Health Center (FQHC) reimbursement under Medicaid or managed care reimbursement structures (or both) to support their recuperative care programs. FQHC reimbursement is an attractive vehicle for support because it typically pays a daily rate to the provider for services based on program costs and many FQHCs are already involved with programs caring for people without homes as part of their mission to care for everyone in the community regardless of their ability to pay. Managed care reimbursement structures are attractive because managed care organizations (MCOs) have flexibility in covering those services through a variety of federally authorized funding mechanisms.

Figure 1 - Recuperative Care Models



[4] NIMRC Medical Respite Care Directory

MCOs can benefit from providing that support because it allows them to deliver better care to members, which is valued by states and members picking a plan. Supporting recuperative care also can financially benefit MCOs by avoidance of higher cost unnecessary hospitalizations or more intensive medical care.

The prevalence of FQHC and managed care supports for recuperative care have developed because of their availability and expedience, but they are not without their drawbacks. FQHC approaches have limited growth potential since there is considerable and extensive administrative burden involved in bringing up and maintaining a successful clinic. Medicaid reimbursement for FQHCs is complex and more costly relative to other forms of primary care. Managed care approaches necessarily focused on Medicaid members enrolled with the managed care organization, which can be a problem if they are enrolled outside of a managed care structure or if they have difficulty in selecting a plan – as is common for people experiencing homelessness who often do not have a consistent address or phone number by which the state or the plan can contact them.

Programs also receive Medicaid support through enrolling as or partnering with Medicaid providers, such as primary care, community nursing, or home health. These approaches informed the exploration of funding options pursued through stakeholder workgroups.

Exploration of Options

The exploration of options began with a focus on the goals of the group. While goals were broadly defined under the statute directing this report, refining the purpose of the group was helpful for the exploration of specific options that followed. The goals finalized by the group included:

- Providing and expanding Medicaid support for existing recuperative care programs in Minnesota
- Establishing an approach to Medicaid funding that will support the establishment of new recuperative care sites in both urban and rural areas
- As far as possible, minimizing complexity and new requirements that would create challenges for either existing or new programs
- Providing the best possible Medicaid supports for all eligible Minnesotans experiencing homelessness while they are recuperating from an acute medical condition, including connection with supportive resources beyond recuperative care
- Beginning implementing Medicaid supports in CY 2024
- Allowing for an approach that can prevent acute care needs as well as providing post-acute care

Based on those goals, HMA explored several potential options for Medicaid support for recuperative care in Minnesota based on other state program approaches and needs particular to Minnesota. Options considered included:

- Standard Medicaid (state plan) benefits such as medical care, case management, or FQHC services
- Bundled payments for groupings of Medicaid services typically provided by recuperative care programs, such as care coordination, wound care, behavioral health, and others
- Managed care benefits, including:

    - Services provided at rates negotiated with managed care organizations (MCOs)
    - Services "in lieu of" other benefits
    - Additional or value-added services provided by plans outside of rate support
    - Reinvestment of managed care savings under a 1915b waiver approach
- Extended home and community-based state plan benefits (1915i or 1915k HCBS programs).
- Home and community-based waiver (HCBS 1915c) services such as personal care, non-medical respite, and attendant services
- Benefits covered under an 1115 demonstration waiver that would allow for greater flexibility and potentially supports not typically available through Medicaid, such as room and board

After in-depth review of options and discussion with stakeholders, HMA conducted an informal poll. Based on that poll and additional discussions, group responses were categorized as described in Table 1:

Table 1 – Stakeholder Preference Categories for Medicaid Supports

Preference	Approach	Reasons for Preference Ranking
Least Preferred	Managed Care	Limited ability to support all members, including those outside of managed care enrollment.
	HCBS Waiver (1915c)	Only able to support members who would otherwise qualify for institutional care.
Less Preferred	FQHC Services	While supportive of some programs, constraints on supports for existing non-FQHC programs and new programs that may not be FQHC based.
	Extended State Plan (1915i or 1915k)	High administrative burden for providers and the state
Preferred	Bundled Payments	Ability to support multiple services under a simplified daily rate structure
	1115 Demonstration Waiver	Ability to support room and board expenses and flexibility in design

Stakeholders and state agency participants held nuanced views on the pros and cons of each approach, but support was clearly strongest for the bundled payment option. Stakeholders also expressed a need for additional support from DHS staff for navigation of Medicaid enrollment, billing, and compliance purposes and the desire for administrative simplification as far as possible within Medicaid program constraints.

In addition to the Medicaid program authority options, admission and discharge criteria for recuperative care was explored with the stakeholder group. The group included several people with clinical training as well as representatives from existing recuperative care programs, who provided informed and thoughtful opinions on the best approach to defining the population for recuperative care services through admit and discharge criteria.

V. Recommendations

Based on the stakeholder engagement meetings, input from DHS and other state agencies, and HMA's Medicaid and behavioral health program expertise, the following menu of recommendations are presented for consideration by the Minnesota Legislature.

Recommendation 1: Establish Medicaid Technical Assistance for Recuperative Care Programs

DHS could be funded and staffed to support recuperative care programs, including specific state staff and supports for recuperative care programs to provide training, assistance, and information related to:

- Recuperative care programs for contracting and working with managed care organizations
- Appropriate credentialing of licensed staff delivering care
- Enrolling, billing, and maintaining compliance with program requirements for Medicaid provider
- General questions on Medicaid programs and policies as they relate to recuperative care

Recommendation 2: Establish Medicaid Support for Care Coordination

DHS could be funded and supported to establish a care coordination benefit for people experiencing homelessness in need of recuperative care that would encompass:

- Clearly defined standards for tracking outcomes of services
- Meeting the needs of people experiencing homelessness through a needs assessment process and development of a care plan for their recuperative care stay and transition back to the community
- Support for transition to a stable housing situation, when possible, but recognizing that transition back to a shelter or other interim solutions will be necessary for some
- Clearly defined expectations and requirements for care coordinators to help with coordinating travel to services and supports such as primary care, physical, occupational, or speech therapy services, medication, behavioral health, social support services, and others during a recuperative care stay and for a brief period post-discharge (up to 60 days) to ensure connection with needed supportive services
- Realistic requirements consistent with the duration of stay and designed to meet the needs of recuperative care programs in coordination with state and federal requirements for Medicaid benefits

Recommendation 3: Establish Medicaid Bundled Payments for Recuperative Care Benefits

DHS could be funded and supported to establish a per diem bundled payment for recuperative care adequate to support:

- Care coordination as described above
- Private Duty Nursing
- Basic Behavioral Health Services, including bachelor's and master's level Counseling and Peer Supports
- Community health workers and appropriate supervision as currently defined under Minnesota statutes and regulations

DHS should be directed to establish controls to prevent billing of recuperative care services concurrently with duplicative services of any kind. For this or other supports, reasonable admission and discharge criteria would also need to be established.

Suggested Approach to Admission and Discharge Criteria

The recuperative care benefit would be directed towards adults (18+) experiencing homelessness who:

- Need short-term (<60 days) acute medical care that can't be safely or effectively delivered while they do not have access to a safe place to stay, such as:
    - Needing care post-discharge from hospital that can't be met without stable housing, or
    - Needing care that prevents their condition from deteriorating – e.g., preventive of an institutional care need, or
    - An attending inpatient MD, DO, NP, or PA determines discharge to a nonexistent or unstable housing setting would be unsafe, and
- Whose care requirements do not meet the level of need for residential treatment – either nursing facility, hospital, or other residential care, and
- Who do not have behavioral health needs that cannot be managed within the recuperative care setting (basic outpatient treatment for both mental health and substance use disorders).

Patients should be discharged when:

- Their acute medical condition has been stabilized, and
- The patient has been connected to ongoing health supports required – for example, primary care appointment, specialist appointment, SUD treatment provider, mental health services, or other, and
- The patient has been connected with social services to address their housing needs, either immediately upon discharge or at some future point as appropriate for the person.

Recommendation 4: Support room and board and other expenses not ordinarily allowed under Medicaid coverage by designating state-only funding streams

Once some or all the Medicaid supports described in recommendations 1-3 are established, DHS could be funded and supported to work with other state agencies on comprehensive recuperative care supports. This approach would use non-Medicaid housing support benefits to fund room and board expenses for recuperative care programs by establishing a braided funding method that would preserve the integrity and trackability of Medicaid and state expenses.

Recommendation 5: Support longer-term strategies for payment of room and board expenses not ordinarily covered by Medicaid through an 1115 demonstration waiver request to the federal government

In the longer term, DHS could be funded and supported to explore establishment of an 1115 waiver that provides housing supports under Medicaid as part of a broader strategic efforts to address the social drivers of health for Minnesotans with Medicaid coverage. 1115 benefits would be coordinated with existing Medicaid housing supports benefits and build on any other options recommended here as adopted by policy makers and

DHHS leadership. Waiver development work is intensive and a timeframe of 2-3 years from initiation to the beginning of implementation is anticipated based on work done in other states to establish this level of comprehensive support for recuperative care.

VI. Appendix

The following organizations were invited to participate in stakeholder meetings to discuss and review options for creating a Recuperative Care Program as a Medicaid benefit in Minnesota.

Agate Housing + Services
Allina
American Indian Development Corporation
Avivo
Bloomington Public Health
Blue Cross Blue Shield Minnesota
Bob Tavani House
Catholic Charities
CentraCare
Essentia Health
Exodus Residence (Catholic Charities)
Fairview Health System
Harbor Light Center
Health Partners
Healthcare for the Homeless
Hearth Connection
Hennepin Health
Higher Ground (Catholic Charities)
Itasca Medical Care
Maple Grove Hospital
Mayo Health System
Minnesota Association of Resources for Recovery & Chemical Health
Minnesota Association of Community Health Centers
Minnesota Association of Community Mental Health Centers
Minnesota Coalition for the Homeless
Minnesota Council of Health Plans
Minnesota Department of Health
Minnesota Hospital Association
Minnesota Housing
Minnesota Interagency Council on Homelessness
Minnesota Medical Association
Native American Community Clinic
North Memorial
Olmsted Medical Center
PrimeWest
Sanford Health
South Country Alliance
St. Louis County Human Services
The Landing Minnesota
Women's Shelter & Support Center
Union Gospel Mission
United Healthcare
University of Minnesota
Zumbro Valley Medical Society