256B.0701 RECUPERATIVE CARE SERVICES.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Habitability inspection" means an inspection that meets the requirements of subdivision 13.

(c) "Provider" means a recuperative care provider that meets the standards for medical respite care programs most recently published by the National Institute for Medical Respite Care.

(d) "Recuperative care" means a model of care that prevents hospitalization or that provides postacute medical care and support services for recipients experiencing homelessness who are too ill or frail to recover from a physical illness or injury while living in a shelter or are otherwise unhoused but who are not sick enough to be hospitalized or remain hospitalized, or to need other levels of care.

Subd. 2. **Recuperative care settings.** Recuperative care may be provided in any setting that meets the habitability inspection requirements in subdivision 13, including but not limited to homeless shelters, congregate care settings, single room occupancy settings, or supportive housing, so long as the provider of recuperative care or provider of housing is able to provide to the recipient within the designated setting, at a minimum:

(1) 24-hour access to a bed and bathroom;

(2) access to three meals a day;

(3) availability to environmental services;

(4) access to a telephone;

(5) a secure place to store belongings; and

(6) staff available within the setting to provide a wellness check as needed, but at a minimum, at least once every 24 hours.

Subd. 3. **Eligibility.** To be eligible for recuperative care services, a recipient must:

(1) not be a child;

(2) be experiencing homelessness;

(3) be in need of short-term acute medical care for a period of no more than 60 days;

(4) meet clinical criteria, as established by the commissioner, that indicates that the recipient needs recuperative care; and

(5) not have behavioral health needs that are greater than what can be managed by the provider within the setting.

Subd. 4. **Total payment rates.** Total payment rates for recuperative care consist of the recuperative care services rate and the recuperative care facility rate.

Subd. 5. **Recuperative care services rate.** The recuperative care services rate is for the services provided to the recipient and must be a bundled daily per diem payment of at least $300 per day. Services provided within the bundled payment may include but are not limited to:

(1) basic nursing care, including:

(i) monitoring a patient's physical health and pain level;

(ii) providing wound care;

(iii) medication support;

(iv) patient education;

(v) immunization review and update; and

(vi) establishing clinical goals for the recuperative care period and discharge plan;

(2) care coordination, including:

(i) initial assessment of medical, behavioral, and social needs;

(ii) development of a care plan;

(iii) support and referral assistance for legal services, housing, community social services, case management, health care benefits, health and other eligible benefits, and transportation needs and services; and

(iv) monitoring and follow-up to ensure that the care plan is effectively implemented to address the medical, behavioral, and social needs;

(3) basic behavioral needs, including counseling and peer support, that can be provided in the recuperative care setting; and

(4) services provided by a community health worker as defined under section 256B.0625, subdivision 49.

Subd. 6. **Recuperative care facility rate.** (a) The recuperative care facility rate is for facility costs and must be paid from state money in an amount equal to the MSA equivalent rate as defined in section 256I.03, subdivision 11a, at the time the recuperative care services were provided. The eligibility standards in chapter 256I do not apply to the recuperative care facility rate. The recuperative care facility rate is only paid when the recuperative care services rate is paid to a provider. Providers may opt to only receive the recuperative care services rate.

(b) Before a recipient is discharged from a recuperative care setting, the provider must ensure that the recipient's medical condition is stabilized or that the recipient is being discharged to a setting that is able to meet that recipient's needs.

Subd. 7. **Extended stay.** If a recipient requires care exceeding the 60-day limit described in subdivision 3, the provider may request in a format prescribed by the commissioner an extension to continue payments until the recipient is discharged.

Subd. 8. **Report.** (a) The commissioner must submit an initial report on coverage of recuperative care services to the chairs and ranking minority members of the legislative committees having jurisdiction over health and human services finance and policy by February 1, 2025, and a final report by February 1, 2027. The reports must include but are not limited to:

(1) a list of the recuperative care services in Minnesota and the number of recipients;

(2) the estimated return on investment, including health care savings due to reduced hospitalizations;

(3) follow-up information, if available, on whether recipients' hospital visits decreased since recuperative care services were provided compared to before the services were provided; and

(4) any other information that can be used to determine the effectiveness of the program and its funding, including recommendations for improvements to the program.

(b) This subdivision expires upon submission of the final report.

Subd. 9. **Provider qualifications and duties.** A provider is eligible for reimbursement under this section only if the provider:

(1) is confirmed by the commissioner as an eligible provider after a pre-enrollment risk assessment under subdivision 10;

(2) is enrolled as a medical assistance Minnesota health care program provider and meets all applicable provider standards and requirements;

(3) demonstrates compliance with federal and state laws and policies for housing stabilization services as determined by the commissioner;

(4) complies with background study requirements under chapter 245C and maintains documentation of background study requests and results;

(5) provides at the time of enrollment, reenrollment, and revalidation in a format determined by the commissioner, proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is $300,000 or less, the provider agency must purchase a surety bond of $50,000. If the provider's medical assistance revenue in the previous year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) ensures all controlling individuals and employees of the agency complete annual vulnerable adult training;

(7) completes compliance training as required under subdivision 11; and

(8) complies with the habitability inspection requirements in subdivision 13.

Subd. 10. **Pre-enrollment risk assessment.** (a) Prior to enrolling a recuperative care provider, the commissioner must complete a pre-enrollment risk assessment of the provider seeking to enroll to confirm the provider's eligibility and the provider's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential provider's history of performing services similar to those required by this section;

(2) whether the services require the potential provider to perform duties at a significantly increased scale and, if so, whether the potential provider has the capability and organizational capacity to do so;

(3) the potential provider's financial information and internal controls; and

(4) the potential provider's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential provider does not have a history of performing similar duties, the potential provider does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential provider ineligible and deny or rescind enrollment. A potential provider may appeal a decision regarding the provider's eligibility in writing within 30 business days. The commissioner must notify each potential provider of the commissioner's final decision regarding the provider's eligibility.

(c) This subdivision is effective July 1, 2025. Any recuperative care provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the provider and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the provider. If an individual moves to another recuperative care provider and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any recuperative care provider enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Subd. 12. **Requirements for provider enrollment; documentation of habitability inspection.** (a) Effective July 1, 2025, to enroll as a recuperative care provider, a provider must submit to the commissioner proof that a habitability inspection of the proposed service setting has been performed and a qualified inspector has deemed the setting habitable.

(b) Any recuperative care provider enrolled prior to July 1, 2025, must submit to the commissioner by July 1, 2026, proof that a habitability inspection of the service setting has been performed and a qualified inspector has deemed the setting habitable.

Subd. 13. **Habitability inspection requirements.** (a) A recuperative care provider providing recuperative care services in an unlicensed setting must ensure that the unlicensed setting is inspected by a qualified inspector with demonstrated knowledge of housing inspection standards and professional experience conducting home inspections. The habitability inspection must include an assessment of potential home-based health and safety risks to ensure the living environment does not adversely affect the occupants' health and safety. Inspectors must evaluate both the habitability and environmental safety of the property, including but not limited to the following characteristics of the unlicensed setting:

(1) adequacy of space for the individuals being served;

(2) indoor air quality and ventilation;

(3) adequacy of safe water supply;

(4) cleanliness of the setting, including kitchen, bathroom, and living spaces;

(5) adequacy of electrical service, outlets, and lighting and absence of electrical hazards;

(6) potential lead exposure;

(7) conditions that may affect health;

(8) conditions that may affect safety;

(9) condition of the building foundation and exterior, including accessibility; and

(10) condition and functionality of equipment for heating, cooling, and ventilation and plumbing.

(b) A recuperative care provider must not provide services in an unlicensed setting prior to receiving a habitability inspection and documentation that the inspector deems the setting habitable. The recuperative care provider must maintain documentation that the inspection occurred and the results of the inspection.

History: *2023 c 70 art 1 s 27; 2024 c 127 art 55 s 11; 1Sp2025 c 9 art 7 s 16-22*