SUMMARY OF EXPRESS TERMS

This rule establishes procedures for the review and approval of applications for a not-for-profit corporation to be certified as an operator of a medical respite program. The Governor's Medicaid Redesign Team II (MRT II) recommended the establishment of standards for medical respite programs as a lower-intensity care setting for patients who are homeless or at risk of homelessness, and who would otherwise require a hospital stay, or lack a safe option for discharge and recovery. The rule requires that medical respite programs meet the minimum operating standards, offer the required services, provide sufficient qualified staff, implement a quality improvement program that is reviewed at least annually, meet the required physical standards of the facility, and maintain true, complete, accurate and current records for each recipient.

Pursuant to the authority vested in the Commissioner of Health by section 2999-hh of the Public Health Law, Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended by adding a new Chapter XV and Part 1007, to be effective upon publication of the Notice of Adoption in the State Register, to read as follows:

A new Chapter XV is added: Medical Respite Program

A new Part 1007 is added: Medical Respite Program

Title 10 of the New York Codes, Rules and Regulations

Chapter XV. Medical Respite Program

Part 1007. Medical Respite Program

Section 1007.1 Applicability. This Part shall be applicable to every person or entity seeking state certification to establish and operate a medical respite program pursuant to article 29-J of the Public Health Law.

Section 1007.2 Definitions

The following words or terms when used in this Part shall have the following meanings:

(a) Commissioner means the Commissioner of the New York State Department of Health.

(b) Department means the New York State Department of Health.

(c) Facility means the physical plant location where the medical respite program provides medical respite services to recipients.

(d) Inspection means periodic scheduled, announced or unannounced onsite survey, inspection or investigation by the department or its contractor to determine compliance by the operator with the applicable statutes and regulations, and may include observation or review of a sample of the medical respite program records to determine the quality and adequacy of the medical respite services.

(e) Medical respite program means the not-for-profit corporation certified by the department to serve recipients whose health condition necessitates the receipt of:

(1) Temporary room and board; and

(2) The provision or arrangement of the provision of health care services and supports; provided, however, that the operation of a medical respite program shall

be separate and distinct from any housing programs offered to individuals or their families who do not qualify as recipients.

(f) Medical respite services means

(1) Temporary room and board; and

(2) The provision or arrangement of the provision of health care services and supports; provided, however, that the operation of a medical respite program shall be separate and distinct from any housing programs offered to individuals or their families who do not qualify as recipients.

(g) Recipient means an individual who:

(1) Has a qualifying health condition that requires treatment or care;

(2) Does not require hospital inpatient, psychiatric inpatient, observation unit or emergency room level of care, or a medically indicated emergency department or observation visit or skilled nursing facility level of care; and

(3) Is experiencing homelessness or is at imminent risk of homelessness. Subject to subparagraph (i) of this paragraph, a person shall be deemed "homeless" if they lack a fixed, regular and adequate nighttime residence in a location ordinarily used as a regular sleeping accommodation for people.

(i) A medical respite program may provide services to a subpopulation of homeless recipients if the medical respite program establishes, to the satisfaction of the department in its sole discretion, that such limitation is

necessary to ensure the availability of a funding source that will support the medical respite program's operations, and such limitations are otherwise consistent with any rules or regulations set forth in this Part. This applies to conditions that may exist in connection with:

(a) Public funding provided by a federal, state or local government entity; or

(b) Private funding from a charitable entity or other nongovernmental source.

(ii) Service plan means a written plan developed by the medical respite program for each recipient that addresses the recipient's physical health, mental health, substance use, and supportive service needs, goals and preferences and discharge indicators while in the medical respite program.

Section 1007.3 Certification; Operating Certificate and Inspection

(a) Certificate of Authority

(1) The department may issue a certificate of authority if the applicant has met the requirements of article 29-J of the Public Health Law and this Part. The department shall evaluate a medical respite program application based on the information contained in and submitted with the application and any other relevant information known to the department. The department will notify an applicant if the application is incomplete and provide the applicant an opportunity to submit any additional information to complete the application.

Any application that remains incomplete 90 days after receiving a request from the department for additional information may be denied.

(i) The operator of a DOH certified medical respite program will be expected to recertify every 5 years to remain compliant.

(2) The following conditions must be satisfied in order for the Commissioner to approve an application:

(i) The applicant has filed an application for certification in such a manner and on such forms as prescribed by the department.

(ii) The application contains the name of the applicant, the location and description of the physical plant, and such other information as the department may require.

(iii) The applicant has demonstrated to the Commissioner's satisfaction that the applicant meets the requirements set forth in article 29-J of the Public Health Law and the rules and regulations set forth in this Part.

(3) The application shall require applicants to submit documentation pertaining to the character, experience, competency and standing in the community of the proposed medical respite program's principals which shall include proposed incorporators, directors, officers, sponsors, and individual operators or partners. This information shall include but not be limited to, demonstration to the Commissioner's satisfaction that the applicant does not:

(i) Appear on any federal or state excluded list;

(ii) Have a record of poor performance in the results of monitoring reviews, complaint investigations, and fiscal or quality control audits performed by the department or any other governmental entity;

(iii) Appear on the Internal Revenue Service charities revocation list or have any other material deficiencies with respect to the operator's not-for-profit status;

(iv) Have a deficiency regarding its registration status with the New York State Attorney General's Charities Bureau, or other deficiency that would preclude it from being in good standing with any agency within the State of New York; or

(v) Appear on any other applicable federal or New York State exclusion lists.

(b) Inspections

(1) The department, whether directly or through a contractor, shall inspect each applicant for and certified medical respite program at least once a year, to ensure that the medical respite will operate, or is operating, in compliance with all applicable laws and regulations, including the regulations in this Part.

Section 1007.4 General Provisions

(a) The operator of a medical respite program must provide, through its employees, contractors and agents, an organized program that:

(1) Meets the operating standards set forth in this Part;

(2) Ensures the protection of recipient rights; and

(3) Promotes the social, physical and mental well-being of recipients.

(b) The operator of a medical respite program must maintain, make available for inspection and submit such statistical, financial, or other information, records or reports relating to the medical respite program as requested by and in the form specified by the Commissioner.

(c) Confidentiality. Operators must maintain the confidentiality of facts and information obtained through its provision of medical respite services and maintained in the recipient's records, which shall not be released to anyone other than the resident, the next of kin or authorized representative(s) of the resident, the managed care organization or other entity providing payment or funding for the medical respite services, the referral source, recipient's health home, as applicable, and any other person or entity as determined necessary for the operator to perform care coordination, except as authorized by the recipient in writing. For the avoidance of doubt, operator shall not release facts and information obtained through its provision of medical respite services and maintained in the recipient's records to any family member or friend of the recipient without the recipient's expressed written authorization.

Section 1007.5 Required Services

(a) Medical respite programs shall provide, or arrange for the provision of, the following services in accordance with this Part:

(1) Temporary room and board, which must include, at a minimum:

(i) A dedicated bed, available to a recipient 24 hours a day, seven days a week.

(ii) Meals in accordance with standards set forth by the Commissioner.

(iii) Compliance by the facility with the physical standards set forth by the department in section 1007.12 of this Part.

(iv) The medical respite program shall provide the department with any information relating to its physical plant environment and equipment necessary to evaluate its application.

(2) Eligibility assessments and development and monitoring of service plans.

(3) Care coordination services.

(i) Arranging for transportation for the recipient to and from health care appointments, which may include arranging for the facility to be an originating site for telehealth (as defined by Section 2999-cc of the Public Health Law) with the consent of the recipient, and arranging for on-site services, as appropriate, by licensed or otherwise qualified providers.

(ii) Assisting recipients with obtaining and maintaining appointments for health care and other supportive services, and ensuring the exchange of information for care and service coordination.

(iii) Identifying and facilitating access to housing and other federal and state benefits or community resources for which the recipient may qualify or benefit from.

(iv) Facilitating family and caregiver interactions.

(v) Coordinating with managed care organizations and their contractors, if applicable, including health homes, to ensure access to service and avoid duplication of services.

(4) Daily wellness checks, or more frequently as otherwise indicated in the Recipient's Service Plan.

Section 1007.6 Personnel

(a) General Requirements.

(1) The operator must provide staff sufficient in number and qualified by training, background and experience to render, at a minimum, medical respite services.

(2) The operator shall ensure a sufficient number of staff members are on-site 24 hours a day, seven days a week. On-site staff must be trained to provide first aid and basic life support services, which shall include but not be limited to training

in opioid overdose prevention and naloxone administration. At least one manager must be available onsite or by telephone 24 hours a day, seven days a week.

(b) Administrator. The operator must designate an individual to be responsible for operating the program in compliance with applicable regulations and executing through direct performance or coordination, the services and functions required by this Part.

(c) Personnel Records. The operator shall maintain personnel records with such information as required by the department.

Section 1007.7 Eligibility and Admission

(a) Recipient Eligibility. An individual is eligible for admission to a Medical Respite Program as a recipient if meets the definition of a recipient set forth in section 1007.2(g) of this Part and:

(1) The individual is 18 years of age or older, unless otherwise authorized in the facility's operating certificate by the department;

(2) The individual has a qualifying medical condition for which they require temporary rest and recuperation and may require access to medical care or other supportive services to support recuperation;

(3) The individual is able to perform activities of daily living with no or minimal assistance, or receives assistance on an interim or part-time basis from a local

social services department, an outside agency, or other formal organization and such assistance is able to be provided in the facility;

(4) The individual is self-directing (i.e., is capable of making choices about the individual's activities of daily living, understanding the impact of the choice, and assuming responsibility for the results of the choice), or receives supervision or direction on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual, including but not limited to a local social services department, an outside agency, or other formal organization;

(5) The individual is able, with direction, to take action sufficient to ensure self-preservation in an emergency;

(6) The individual does not require hospital inpatient, observation unit or emergency room level of care, or a medically indicated emergency department or observation visit or skilled nursing home level of care; and

(7) The individual does not pose a risk of safety to themself, other recipients or staff, as determined in the reasonable discretion by the medical respite program operator.

(b) Admission.

(1) An operator must admit, retain and care for only those individuals who do not require services beyond those the operator is authorized to provide.

(2) An individual must cooperate in the medical respite program's assessment and be determined assessed as eligible for admission by the medical respite program.

(3) An operator shall obtain documentation from the referring entity or person of the medical need for medical respite.

(4) Admission Agreement. Each recipient must sign an admission agreement in order to be admitted to a medical respite program. A signed copy, together with a copy of the medical respite program's code of conduct and rules, and the recipient's rights shall be provided to the recipient. The admission agreement, at a minimum, shall specify:

(i) The effective date of the agreement;

(ii) Any rules of the program related to hours of open operation and visitation;

(iii) That the medical respite program shall discharge the recipient at such time as the recipient no longer qualifies for medical respite services;

(iv) The discharge planning process, which shall be consistent with the requirements set by the department;

(v) That the medical respite program shall be permitted to discharge a recipient immediately, notwithstanding the discharge planning process requirements in section 1007.8 of this Part, in the event that the recipient's behavior poses an imminent risk of death or serious physical harm to the recipient or others, or repeated behavior of the recipient which

directly impairs the well-being, care or safety of the recipient or any other recipient or which substantially interferes with the orderly operation of the medical respite program. Details of any such discharge shall be made a part of the recipient's record pursuant to section 1007.14(c) of this Part;

(vi) That the recipient's waiver of any provision of the admission agreement is null and void;

(vii) The recipient's right to terminate the admission agreement and vacate the medical respite program at any time; and

(viii) Any other provision specified by the department.

(5) If the recipient is sight-impaired, hearing-impaired, has limited-English proficiency or is otherwise unable to comprehend English or printed matter, the operator shall ensure that the information in the vital documents, including the admission agreement, the code of conduct, and the facility rules and recipient rights information, are made available in a manner comprehensible to the recipient, including, as appropriate, translation of the documents into commonly spoken languages other than English or through the use of an interpreter.

(c) Assessment. Prior to admission, the medical respite program shall assess or arrange for the assessment of each referred individual for eligibility for admission to the medical respite program.

(d) Service Plan. The medical respite program shall develop a service plan based on the needs identified during a recipient's assessment and revise the service plan as needed

based on the recipient's reassessment which shall be performed, as needed, but no less frequently than every two weeks, to ensure the recipient's needs are addressed by the service plan.

Section 1007.8 Discharge

(a) Discharge Planning.

(1) The medical respite program shall discharge recipients when they no longer qualify for medical respite services, as defined in section 1007.7(a) of this Part.

(2) If housing has not been identified when the recipient is ready for discharge, all housing packets and applications should be transferred to the recipient's discharge location, which has agreed to continue to assist the recipient with securing permanent housing.

(3) The medical respite program shall begin discharge planning upon a recipient's admission and shall engage in discharge planning throughout a recipient's stay at the facility.

(4) In order to discharge a recipient, the medical respite program shall:

(i) Develop a discharge plan that identifies and provides referral to potential housing options, healthcare providers, and supportive services for the recipient;

(ii) Provide, at least 14 days advance written notice, of the discharge to the recipient, and as applicable and appropriate, the recipient's managed care

organization, referring entity or person, discharge location, health home, and family and caregivers, provided, any required authorization as set forth in section 1007.4(c) of this Part is obtained;

(iii) Coordinate the discharge with the recipient's managed care organization, discharge location (e.g. shelter or housing provider, family member or friend's home, etc.), the referring entity or person, as applicable, and if applicable, the health home, as described in section 1007.5(a)(3)(v) of this Part, provided, any required authorization as set forth in section 1007.4(c) of this Part is obtained;

(iv) Provide the recipient with the discharge summary, which shall comply with subdivision (b) of this section; and

(v) Comply with any other requirements established by the department.

(b) Discharge Summary.

(1) Upon discharge, a discharge summary shall be provided to the recipient, recipient's primary provider, if applicable, the managed care organization and health home, and such other persons or entities requested by the recipient. The discharge summary must include the following:

(i) Written medication list and medication refill information (i.e., pharmacy), to the extent known;

(ii) Admitting diagnosis;

(iii) Length of stay in the medical respite program;

(iv) Ongoing medical problems or conditions, to the extent known;

(v) Instructions for accessing relevant resources in the community, including shelters or other housing options;

(vi) List of follow-up appointments and contact information for treating providers, to the extent known;

(vii) Special medical instructions (e.g., weight-bearing limitations, dietary precautions, allergies, wound orders), to the extent known;

(viii) Pain management plan, to the extent known; and

(ix) Primary point(s) of contact for the recipient.

(c) The medical respite program shall ensure that adequate protocols are in place for transferring a recipient's information, or making available access to the recipients records, to appropriate providers, the recipient's managed care organization, and health home, if applicable, in accordance with privacy and confidentiality laws and regulations and pursuant to any legally required authorization.

(d) Discharge.

(1) An operator of a medical respite program may discharge a recipient under the terms set forth in this Part, guidance, and the facility rules, when the recipient's public or private payor no longer authorizes medical respite services, when

funding is no longer available, when the recipient no longer qualifies for medical respite under section 1007.7 of this Part.

(2) A recipient may not be discharged from a medical respite facility until the following procedures are observed:

(i) the recipient has been given written notice, by the operator of a medical respite program or the managed care organization, 14 days in advance of the discharge, which indicates the decision and of the reasons therefor; and for Medicaid enrollees, such notice shall include a statement that the recipient may request a fair hearing in which to challenge the discharge decision, and shall describe how a fair hearing may be requested and obtained;

(ii) the recipient's need for protective services for adults, preventive services, or for other social services has been evaluated and an appropriate referral has been made, if necessary; and

(iii) if criminal activity may have occurred, the appropriate law enforcement agency has been contacted.

(3) (i) For Medicaid enrollees, a decision by an operator of a medical respite program to discharge a recipient may be challenged by the recipient or their representative in a fair hearing requested pursuant to Part 358 of Title 18 of the New York, Codes, Rules & Regulations (NYCRR), as applicable, and the recipient may have

the right to receive aid continuing pursuant to 18 NYCRR section 358-3.6, if a fair hearing is timely requested pursuant to 18 NYCRR section 358-3.5.

(ii) A decision by a managed care organization to no longer authorize medical respite services may be challenged in accordance to applicable rules and guidance, including article 49 of the Public Health Law, 18 NYCRR Parts 358 and 360-10, and Sections 431 and 438 of Title 42 of Code of Federal Regulations.

(4) A recipient who is found upon internal appeal or fair hearing decision to have been wrongfully discharged from a medical respite program must be offered an opportunity to return to the facility as soon as an appropriate vacancy becomes available. No such opportunity may be offered if the recipient no longer meets the requirements for medical respite services.

(5) A recipient may be involuntarily discharged from a medical respite facility without advance written notice as described in paragraph (2)(i) of this subdivision if the basis for the discharge is that the recipient satisfies the requirement for immediate discharge pursuant to section 1007.7(b)(4)(v) of this Part or has been absent from the facility for more than 48 hours without having complied with the facility's rules concerning absences and has not been readmitted to the facility. The 48-hour period begins at the start of the period of the unauthorized absence. A written record of all unauthorized absences and involuntary discharges must be maintained by the facility pursuant to sections 1007.14(c) and (d) of this Part.

Section 1007.9 Quality Improvement Activities; Policies and Procedures

(a) A medical respite program shall implement a quality improvement program that provides for an annual or more frequent review of the medical respite program. The quality improvement program must evaluate, at a minimum, a profile of the characteristics of recipients admitted to the program, the services and degree of services most utilized, the length of stay and use rate, recipient need for care and services, recipient feedback about services received, and disposition upon discharge.

(b) The quality improvement process must:

(1) Include an evaluation of all services in order to enhance the quality of care and to identify actual or potential problems concerning medical respite services;

(2) Review accident and incident reports, recipient complaints and grievances, recipient feedback, and the actions taken to address problems identified by the process;

(3) Develop and implement revised policies and practices to address problems found and the immediate and systematic causes of those problems; and

(4) Assess the impact of the revisions implemented to determine if they were successful in preventing recurrence of past problems.

(c) The results of the quality improvement process shall be (1) reported to the chief executive officer of the operator of the medical respite program; (2) maintained at the facility; and (3) available for review and inspection by the department. Nothing in this subdivision (c) shall be interpreted as prohibiting the operator from sharing the results of the quality improvement process with any other person or entity.

(d) The medical respite program shall adopt policies and procedures as required by the department, which shall, at a minimum, include policies and procedures governing:

(1) Emergency/disaster response plan;

(2) Eligibility assessment and service plan;

(3) Discharge planning and length of stay;

(4) Care coordination;

(5) Medication storage; and

(6) Infection control.

Section 1007.10 Food Service

(a) The operator of a medical respite program shall provide or arrange for meals to be provided to recipients that are balanced, nutritious and adequate in amount and content to meet their dietary restrictions and needs, and accommodate any religious dietary restrictions.

(b) Meal service shall be provided at the facility. Meal service may be provided directly or through contractual arrangements.

(c) At a minimum, recipients shall be provided with the opportunity to obtain breakfast, lunch and evening meals at regularly scheduled times, and two snacks a day.

Section 1007.11 Recipient Rules

(a) The operator of a medical respite program shall adopt rules governing a recipient's day-to-day life in the program and post these rules in a location accessible to recipients of the facility and visitors.

(b) Prior to admission, each recipient must be provided with a copy of the medical respite program's code of conduct, facility rules, and recipient's rights, which shall comply with all requirements set by the department. The recipient shall sign an acknowledgment of a receipt of the code of conduct, facility rules, and recipients rights; a hard or electronic copy of the signed acknowledgement and the code of conduct, facility rules, and

recipients rights shall be provided to the recipient and a hard or electronic copy shall be maintained by the operator at the facility in the recipient's records.

Section 1007.12 Physical Standards

(a) General.

(1) The operator must maintain the facility in a good state of repair and sanitation and in conformance with applicable state and local building codes and other laws.

(2) The facility shall be appropriate for a recipient resting and recuperating from the recipient's qualifying condition.

(3) The facility or a dedicated portion of the facility must be used exclusively to operate a medical respite program. An operator may request prior permission from the department, in writing, to utilize space for other activities. The operator must demonstrate that the proposed use is not incompatible with the medical respite program, will not be detrimental to recipients and complies with applicable local codes.

(b) Flood protection. If the facility is located in a flood plain, the commissioner may require that the facility comply with any, or all, of the following:

(1) Health facility footings, foundations, and structural frame shall be designed to be stable under flood conditions.

(2) The facility shall be designed and capable of providing services necessary to maintain the life and safety of patients and staff if floodwaters reach the 100-year flood crest level and shall include the following:

(i) electrical service, emergency power supply, heating, ventilating and sterilizers;

(ii) fire alarm system;

(iii) dietary service;

(iv) an acceptable alternate to the normal water supply system; and

(v) an acceptable emergency means of storage and/or disposal of sewage, biological waste, and garbage.

(c) Smoke and fire protection.

(1) A supervised smoke detection system, which is listed by an acceptable testing laboratory, shall be installed in the following locations:

(i) in each corridor at least every 40 feet on center, or less if required by the manufacturer;

(ii) at the top of all stairways, elevator and hoist way and other unsealed shafts; and

(iii) in attics, basements and open floor areas designated for public or recipient use, at least one detector for each 1,000 square feet of open or unpartitioned space.

(2) In a facility that is approved by the department to house fewer than 40 recipients, which has a fire protection system capable of being directly connected to the local fire department or a central station, at least one of the fire protection systems shall be so connected unless local fire officials refuse to establish such a connection. The operator must document such refusal.

(3) There shall be at least two means of egress from each floor designated for public or recipient use. The required means of egress shall:

(i) be remote from one another;

(ii) be open in the direction of exit travel;

(iii) be equipped with panic (quick-release) hardware;

(iv) be equipped with a self-closing device;

(v) not pass through a bedroom or bathroom; and

(vi) be clear of trash, clutter or obstruction and freely accessible at all times.

(4) Illuminated exit signs shall be installed at each required exit. When the exit is not visible, illuminated directional exit signs shall be installed in all corridors to indicate the location of each means of egress.

(5) Emergency lighting which is listed by an acceptable testing laboratory and powered by battery or an automatic generator shall be installed in all exit hallways, stairwells and public areas.

(6) Fire extinguishers which meet National Fire Protection Association standards, and which are appropriate for the type of fire which may occur at the site of installation shall be:

(i) placed at accessible locations on each floor and each wing;

(ii) wall-hung; and

(iii) properly charged and checked.

(7) Evacuation procedures which set forth areas of refuge, the duties of all staff and recipients, and directions for the rapid evacuation of the premises shall be posted in a conspicuous place on each floor and wing.

(8) The following are fire hazards and are prohibited:

(i) smoking in other than designated areas;

(ii) portable electric space heaters;

(iii) self-contained, fuel-burning space heaters;

(iv) nonmetal containers for furnace ashes;

(v) accumulation of combustible materials in any part of the building;

(vi) storage of flammable or combustible liquids in anything other than closed containers listed by an acceptable testing laboratory;

(vii) cooking appliances in a recipient's room; and

(viii) overloaded electrical circuits.

(d) Safety procedures.

(1) Neither devices such as chain locks, hasps, bars, nor other items such as furniture, can be used in any recipient use area in a way that would inhibit access to an exit or the free movement of recipients.

(2) Doors in recipients' sleeping units may be secured by the recipient provided such doors can be unlocked from the outside by facility attendants or employees or security staff at all times.

(3) Recipients must not have access to storage areas used for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous or flammable materials.

(4) Lighting must be adequate in all spaces. Night lights must be provided and working in all hallways, stairways and bathrooms which are not private.

(5) Hallways, corridors and means of emergency egress must be free from obstruction and may not be used for storage of equipment or trash.

(e) Furnishings and equipment.

(1) The operator shall provide furnishings and equipment which support daily activities and are durable, clean, appropriate to function and do not endanger recipient health, safety and welfare.

(2) The operator shall furnish each recipient with a single bed that is a minimum of 30 inches in width. Each bed shall be substantially constructed, in good repair, and have:

(i) a clean, comfortable and well-constructed mattress, standard in size for the bed;

(ii) a cover sufficient to protect against insect infestation; and

(iii) one clean and comfortable pillow of average bed size.

(3) Recipients shall be supplied with the following in quantities sufficient to meet the needs of the recipient:

(i) suitable sheets, pillowcases, pillows, and blankets;

(ii) towels;

(iii) soap;

(iv) toilet tissue; and

(v) menstrual products.

(4) Bed linens, blankets and towels shall be:

(i) clean and washable;

(ii) free from rips and tears; and

(iii) available when changes are necessary.

(5) A complete change of bed linens and towels shall be provided to recipients at entry, at least once a week, and more often if needed.

(6) Sufficient numbers of noncombustible trash containers with covers shall be available.

(7) All operable windows must be equipped with screens and where necessary to provide privacy, with curtains, shades or other appropriate widow covering to ensure privacy.

(8) Light fixtures must be shaded to prevent glare.

(9) Heating and cooling systems must be in good working order.

(10) Suitable fans should be provided to recipients when necessary to maintain reasonable air circulation.

(11) Laundry facilities, either on-site in a clean, dry, well-lighted area, or at a nearby commercial laundromat. Reasonable accommodations will be provided for recipients who are unable do their own laundry.

(12) A telephone or telephones must be available for recipient to use and receive calls at no cost to the recipient.

(13) High-speed internet must be available for recipient use at no cost, whether on a device owned by the operator or on the recipient's personal device(s).

(14) Medication storage, including refrigeration for medications requiring refrigeration.

(15) The operator shall maintain areas suitable for posting required notices, documents and other written materials in locations visible to, and accessible to, recipients, staff and visitors.

(f) Housekeeping.

(1) The operator shall maintain a clean and comfortable environment.

(2) All areas of the facility shall be free of vermin, rodents and trash.

(3) All areas of the facility, including, but not limited to, the floors, walls, windows, doors, ceilings, fixtures, equipment and furnishings shall be clean and free of odors.

(4) Blankets and pillows shall be laundered as often as necessary for cleanliness and freedom from odors.

(5) Adequate, properly maintained supplies and equipment for housekeeping functions shall be onsite for designated staff to maintain cleanliness.

(g) Maintenance.

(1) The operator of each medical respite program shall ensure the continued maintenance of the facility in accordance with this Section.

(2) The building and grounds shall be maintained in a clean, orderly condition and in good repair.

(3) All equipment and furnishings shall be maintained in a clean, orderly condition and in good working order.

(4) Electrical systems, including appliances, cords and switches, shall be maintained in good working order.

(5) Entrances, exits, steps and outside walkways shall be in good repair and shall be kept free from ice, snow and other hazards.

(h) Space requirements.

(1) Medical respite services. The facility shall have appropriate space for recipients to meet privately with staff or external service providers for purposes of eligibility assessments, developing and monitoring of service plans, care coordination, and, as applicable, the on-site provision of health services.

(2) Bath and toilet facilities.

(i) There shall be a minimum of one toilet and one sink for each four recipients, and one tub or shower for each four recipients.

(ii) Toilet and shower areas must be accessible and in working order with hot and cold water 24 hours a day.

(iii) Hot water for bathing and washing must be maintained at no less than 110 degrees Fahrenheit.

(iv) All toilet and showers shall be vented by means of natural or mechanical ventilation to the outside air.

(v) All toilet and shower areas shall be properly enclosed and separated from other areas by ceiling-high partitions and doors.

(3) Bedrooms in medical respite programs.

(i) In single occupancy sleeping rooms, a minimum of 80 square feet per recipient shall be provided.

(ii) In sleeping rooms for two recipients, a minimum of 60 square feet per recipient shall be provided. No more than two recipients shall share a sleeping room.

(iii) A minimum of three feet, which is included in the per recipient minima, shall be maintained between beds and for aisles.

(iv) If partitions are used to subdivide sleeping areas within the same room, their minimum height shall be sufficient to afford individual privacy, approximately four feet.

(v) Partitions separating sleeping rooms from other rooms shall be ceiling high and smoke-tight.

(vi) Bedrooms or sleeping areas must open directly into exit corridors.

(vii) A passageway or corridor may not be used as a bedroom.

(viii) With the exception of single bedrooms with locking doors, bedrooms shall have individual, lockable storage lockers for recipient belongings. Each locker shall be large enough to accommodate winter clothing.

(i) Kitchens in living areas.

(1) Kitchens or food preparation areas, if any, must be well-lighted and ventilated, and comply with all State and local codes and regulations including, but not limited to, those relating to fire protection, safety, sanitation and health.

(j) Reporting.

(1) In the event of a heating, water, or electrical failure that is more than four hours in duration, the discovery of an environmental hazard such as lead paint or asbestos, or the discovery of a defect in the physical plant or structure of a facility that may threaten the health and well-being of recipients, the operator will immediately notify the Department of Health by e-mail or telephone.

Section 1007.13 Contracts

(a) In the event that an operator of a medical respite program contracts with a separate independent entity to perform any of its operations, the following conditions shall apply:

(1) The contractor shall demonstrate to the satisfaction of the operator that the contractor is financially stable and able, by reason of past performance or like qualification, to perform the duties delegated by the operator.

(2) If required, the contractor shall be certified by any appropriate local or State agency or unit of government, and shall comply with said regulations. Documentation of such certification and compliance shall be provided to the operator and shall be available for inspection by the department.

(3) The operator shall remain responsible for oversight of any functions delegated to the contractor, the contractor's compliance with all applicable laws and regulations, and the operation of the facility regardless of the existence of any contract.

(4) The contract shall:

(i) be in writing, dated and signed by all parties;

(ii) adhere to all legal requirements under the Not-For-Profit Corporation Law;

(iii) include each party's responsibilities and functions;

(iv) include all financial arrangements and charges, which shall be consistent with fair market value;

(v) specify those powers and duties delegated to the contractor by the operator;

(vi) specify that the powers and duties not delegated to the contractor remain with the operator;

(vii) provide that the operator retains the authority to discharge any person working in the facility;

(viii) state the terms by which the contractor may hire and discharge persons working in the facility or for the medical respite program;

(ix) require the contractor to comply with all applicable provisions of law and regulations;

(x) require the contractor to provide all information required by the department, and to cooperate with the department in carrying out inspection and enforcement activities;

(xi) state that in the event the contractor proposes to subcontract any delegated functions, the subcontractor must be a signatory to the agreement between the operator and the contractor, which must expressly provide for the subcontracting of delegated functions; and that the subcontractor may be terminated by the contractor or the operator;

(xii) stipulate that the operator, notwithstanding any other provisions of the contract, remains responsible for operation of the medical respite program in compliance with applicable laws and regulations; and

(xiii) specify the terms of the contract and the provisions governing renewal and termination prior to expiration.

(5) A copy of each contract shall be retained on file by the operator and shall be available for inspection.

Section 1007.14 Records

(a) The operator shall collect and maintain such information, records or reports as set forth in this Part and as otherwise determined by the department.

(b) The department or its designee may examine the books and records of any facility to determine the accuracy of the annual financial statement, or for any other reason deemed appropriate by the department to effectuate the purposes of these regulations.

(c) Recipient Records.

(1) The operator shall maintain true, complete, accurate and current records for each recipient.

(2) Records shall be maintained at the facility and shall be available for review and inspection by the department.

(3) Records shall be maintained in a manner that assures recipient privacy, security and confidentiality;

(4) Records shall be accessible to medical respite program staff to use solely in the provision of medical respite services, as well as emergency services.

(d) At a minimum, the operator shall maintain:

(1) For each recipient:

(i) the signed admission agreement;

(ii) the signed consents or authorizations necessary to permit sharing of the recipient's health information and other medical respite program information, including, without limitation, for purposes of payment, care coordination, and discharge planning;

(iii) the reasonable accommodation requests, decisions, and fulfillment measures, if applicable;

(iv) an inventory of any personal property held in custody for the recipient by the operator;

(v) a copy of the service plan, as updated;

(vi) a record of the services provided to the recipient throughout the temporary residence, including copies of any applications submitted, the outcomes or pending nature of those applications, and the forwarding of that information to the next residence and/or a care manager or care coordinator;

(vii) personal data, including identification of the recipient's next of kin, family and sponsor, and the name and address of the person or persons to be contacted in the event of an emergency;

(viii) a copy of the recipient's assessment(s);

(ix) documentation that the notice of discharge was timely provided; and

(x) a copy of the discharge summary and the discharge notices and any appeals and the related decision.

(e) Program Records.

(1) The operator shall maintain true, complete, accurate and current records that document operation and maintenance of the facility.

(2) At a minimum, the medical respite program shall retain in hard copy or electronically:

(i) daily census reports

(ii) incident reports;

(iii) copies of grievances made and the operator's responses to the same;

(iv) a copy of each version of the recipient's code of conduct, facility rules and recipient's rights;

(v) a current list of all recipient who require evacuation assistance during an emergency and the type of assistance required;

(vi) a chronological admission and discharge register, consisting of a listing of recipients registered in and discharged from such facility by name, age and sex of recipient, and place from or to which the recipient is registered or discharged;

(vii) program records, including policies and procedures, agreements with contractors, emergency plans and records of evacuation drills;

(viii) food service records, including menus and food purchase records;

(ix) records of maintenance of the physical plant;

(x) staff records, including personnel procedures, job descriptions, staffing schedules, identification of individual employees, and payment records; and

(xi) certificates or reports issued by local and other State jurisdictions related to the facility operations, on file and readily accessible for department review, or posted, if required.

(f) Records Retention.

(1) Records required by the department, excepting financial records of the previous operator, shall be retained in the facility upon change of operator.

(2) Records relating to a recipient shall be retained for six years after death or discharge of a recipient or longer if required under applicable law, regulation or managed care organization contract.

(3) Program records, business records, and records relating to application or renewal for an operating certificate shall be retained for ten years.

(4) These records shall be maintained at the facility, unless written authorization is given by the department for record retention in another location, and shall be available for review and inspection by the department.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law (PHL) section 2999-hh authorized the Department of Health to certify a not-for-profit corporation as an operator of a medical respite program, and to make regulations to establish procedures to review and approve applications for such certification.

Legislative Objectives:

To establish procedures for the review and approval of applications for a not-for-profit corporation to be certified as an operator of a medical respite program.

Needs and Benefits:

The Governor's Medicaid Redesign Team II (MRT II) recommended the establishment of standards for medical respite programs as a lower-intensity care setting for patients who are homeless or at risk of homelessness, and who would otherwise require a hospital stay, or lack a safe option for discharge and recovery. PHL section 2999-hh, as the statute authorizing the establishment of procedures for the review and approval of applications from a not-for-profit corporation to be certified as an operator of a medical respite program, has a legislative finding that increased risks of adverse health outcomes exist for individuals lacking access to safe housing. Medical respite programs provide care to homeless individuals who are at imminent risk of homelessness and who are too sick to be on the street or in a traditional shelter, but not sick enough to warrant inpatient hospitalization. They provide short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing on-site medical care and other supportive services.

These regulations are intended to establish procedures for the review and approval of applications from a not-for-profit corporation (NFP) to be certified as an operator of a medical respite program. NFP's who wish to operate a medical respite residential care facility must submit an application for certification. Once approved, NFPs must follow the regulations and guidance of the Department of Health.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties.

Cost to State Government:

These rules will establish procedures for the review and approval of applications from a not-for-profit corporation to be certified as an operator of a medical respite program. The State will incur the costs of the review and compliance surveillance. The Program has $5 million in state funding for inspections and grants.

Costs to Local Government:

There will be no additional cost to local governments or county owned facilities as a result of these rules.

Costs to the Department of Health:

There will be no additional administrative cost to the Department of Health as a result of these rules.

Local Government Mandates:

These rules will not impose any program, service, duty, additional costs, or responsibility on any county, city town, village school district, fire district, or other special district.

Paperwork:

Medical respite programs will be required to maintain the following records:

- Financial records
- Recipient records
- Program records

Records must be kept for seven years.

Duplication:

These rules do not duplicate existing State or federal requirements.

Alternatives:

These rules are made to establish procedures for the review and approval of applications from a not-for-profit corporation to be certified as an operator of a medical respite program, as authorized by PHL section 2999-hh. No alternatives were considered.

Federal standards:

These rules do not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance schedule:

The rules would be effective upon publication of the Notice of Adoption in the State Register.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas. There are no further compliance requirements created by the amendment.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

No job impact statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent from the nature of this amendment that it will not have an adverse impact on jobs and employment opportunities.

SUMMARY OF ASSESSMENT OF PUBLIC COMMENT

A Notice of Revised Rule Making for the NYS Medical Respite Program was published in the State Register on November 8, 2023. The New York State Department of Health ("the Department of Health" or "the Department") received over 40 comments, which were variously submitted by the following six stakeholder groups: Comunilife; the Health and Housing Consortium, Inc.; National Health Care for the Homeless Council/National Institute for Medical Respite Care; NYC Department of Social Services, Human Resources Administration; NYC Health + Hospitals; and Health x Housing Lab at NYU Grossman School of Medicine.

Commenters reiterated their support for this Medical Respite Rule Making and expressed approval for various revisions and clarifications made in response to the first round of public comments, including provisions related to eligibility determinations, special accommodations, care coordination, service plans, recordkeeping, and food service, among other topics.

Some commenters requested still further clarification of requirements for one or more aspects of medical respite care, such as staffing, eligibility, services, discharge procedures, fair hearing rights, and facility standards. Where such clarification is not already available in existing federal, state, and local laws, regulations, and codes, the Department will provide additional information in sub-regulatory guidance and technical assistance webinars.

After evaluating all comments received, the Department of Health determined that no changes to the Revised Rule are necessary.

ASSESSMENT OF PUBLIC COMMENT

1. Comment Summary: The Department of Health should reconsider our recommendation that medical respite operators must have a trained medical professional (either physician, nurse practitioner, physician assistant, or registered nurse) available onsite or by telephone 24 hours a day. If this is not possible, the Department of Health should require that a trained medical professional provide clinical oversight by, for example, regularly reviewing recipients' medical records or periodically visiting the medical respite site.

Comment Response: A clinical staff onsite or available 24/7 is permitted but not required. Given that the objective of medical respite care is to allow recipients to rest, recuperate, and access care coordination in a safe place, the Department believes that requiring a manager to be available onsite or by telephone 24 hours per day is sufficient. Additionally, medical respite programs may leverage existing clinical on-call services such as telemedicine and primary care doctors' on-call options. The Department will provide further information about staffing requirements in sub-regulatory guidance.

2. Comment Summary: We agree with the requirement that a program manager be available either onsite or by telephone 24/7. However, we feel that medical respite programs should also be required to have personnel in roles such as social worker, care manager, health aide, registered nurse, housing navigator, security staff, and facility staff.

Comment Response: The Department will provide further information about staffing requirements in sub-regulatory guidance.

3. Comment Summary: As a healthcare system, we recommend more specificity in the language about a qualifying health condition so that there is standardization across all payors. In

our experience, medical respite has been appropriate for individuals requiring wound care, physical/occupational therapy, medication management, and psychiatric stabilization.

Comment Response: Qualifying health conditions will be further defined in sub-regulatory guidance.

4. Comment Summary: There is no mention of medical respite for pre-surgical needs. This should be explicitly stated as a qualifying need for medical respite.

Comment Response: A "recipient" is defined in section 1007.2 (f)(1) as someone who "Has a qualifying health condition that requires treatment or care." Someone who needs surgery has a health condition that requires treatment or care. Additional details about qualifying health conditions will be provided in sub-regulatory guidance.

5. Comment Summary: We believe that behavioral health conditions should not be excluded as a qualifying health condition.

Comment Response: The proposed regulations do not exclude behavioral health conditions as a qualifying condition. A "recipient" is defined in section 1007.2 (f)(1) as someone who "Has a qualifying health condition that requires treatment or care"; this definition encompasses individuals who have behavioral conditions. Additional details about qualifying health conditions will be provided in sub-regulatory guidance.

6. Comment Summary: The Department of Health should clarify the qualifying admission criteria that "The individual is able, with direction, to take action sufficient to ensure self-preservation in an emergency." For example, our respite sites have some patients who are non-ambulatory and may not be able to self-preserve in an emergency without staff assistance but who meet all other proposed admission criteria, such as being able to self-direct and perform

activities of daily living with minimal assistance. Additionally, regulations or sub-regulatory guidance should identify requirements for assisting such individuals in an emergency.

Comment Response: Medical respite programs are required to abide by all federal, state, and local laws, regulations, and codes, including those related to individuals with disabilities. As reasonable accommodations are already required and individuals with disabilities are protected from discrimination, no additional provision is necessary. The Department's medical respite program toolkit includes a sample Emergency Preparedness and Response Plan to further guide program operators on this topic.

7. Comment Summary: Qualifying criteria for admission into a medical respite program is that "the individual does not pose a risk of safety to… other recipients or staff." We recommend that patients on the sex offender registry be explicitly ineligible for admission into medical respite.

Comment Response: The medical respite program must conduct a pre-admission assessment of any potential recipient to ensure the program is capable of meeting the individual's needs. The Department will provide additional guidance about recipient eligibility in sub-regulatory guidance.

8. Comment Summary: The Department of Health should clarify the expectations for revisions and reassessments to a recipient's service plan. Requiring a whole service plan reassessment every 14 days may not be necessary. The Department of Health should broaden the regulation to require "a regular review" or a reassessment "as needed."

Comment Response: The Department does not consider it an undue burden on medical respite providers to reassess the service plan every 14 days, as this does not necessarily entail writing an entirely new plan. Additionally, medical respite providers will have the option to use the

Department of Health's service plan template, which is designed to facilitate the planning process.

9. Comment Summary: We believe that the payor, respite operator, and healthcare provider should formulate a care plan at the beginning of a patient's stay that includes the anticipated discharge date from respite. The length of stay should be left to the discretion of the respite operator, in consultation with the patient's care managers and healthcare provider.
Comment Response: This is clarified in sub-regulatory guidance.

10. Comment Summary: In addition to coordinating with Health Homes, we believe that medical respite operators should coordinate with any case management teams assigned to patients, including, but not limited to, local Assertive Community Treatment (ACT), Intensive Mobile Treatment (IMT), and Safe Option Support (SOS) teams.
Comment Response: Care coordination requirements, including which entities should be actively engaged in care coordination, are included in sub-regulatory guidance.

11. Comment Summary: The Department of Health should clarify the expectations for hospitals to share appropriate patient records, participate in care coordination, and collaborate on discharge plans. Hospitals should also be required to provide 30 days of medications, as needed.
Comment Response: The role and expectations of the referring provider are outlined in sub-regulatory guidance.

12. Comment Summary: The Department of Health should clarify requirements for daily wellness checks.
Comment Response: Clarification of wellness check requirements will be provided in guidance.

13. Comment Summary: Does arranging transportation include public transportation?

Comment Response: All Medicaid members are entitled to non-emergency medical transportation using the most medically appropriate and cost-effective level of transportation, which includes public transportation. It is the expectation that the medical respite program would help coordinate this benefit for medical respite recipients. Additional information about the benefit and care coordination expectations will be provided in sub-regulatory guidance.

14. Comment Summary: The Department of Health should clarify requirements for medication storage. These requirements should be designed to ensure that medication is locked, safe and secure, and available 24/7 under provider supervision.

Comment Response: Additional information regarding medication storage requirements will be provided in sub-regulatory guidance.

15. Comment Summary: The Department of Health should add medication management, including assistance with insulin administration or long-acting injectable (LAI) administration, to 1007.5 Required Services.

Comment Response: Additional information about the services medical respite must provide and the staff medical respite must employ, in addition to the services and staff that go beyond the minimum requirements, will be provided in sub-regulatory guidance.

16. Comment Summary: The Department of Health should add basic assistance with ADLs as needed during the short-term convalescence period to 1007.5 Required Services.

Comment Response: Recipient eligibility criteria in section 1007.7(a)(3) specifies that "The individual is able to perform activities of daily living with no or minimal assistance, or receives assistance on an interim or part-time basis from a local social services department, an outside

agency, or other formal organization and such assistance is able to be provided in the facility." This means that individuals who require minimal assistance with ADLs but do not qualify to receive services for assistance with ADLs will be assisted with ADLs by the medical respite program. Sub-regulatory guidance clarifies the definition of “minimal assistance with ADLs” and specifies minimum service and staffing requirements as well as allowable service and staffing models that go beyond the minimum requirements.

17. Comment Summary: The Department of Health should expand 1007.5 Required Services to define a process for hospitals to submit reasonable accommodation requests on behalf of individuals with short- or long-term disabilities.

Comment Response: Medical respite programs are required to abide by all federal, state, and local laws, regulations, and codes, including those related to individuals with disabilities. As reasonable accommodations are already required and individuals with disabilities are protected from discrimination, no additional process is necessary. Forthcoming sub-regulatory guidance directs medical respite programs to seek input from referring providers and specifies several points in the referral, assessment, and service planning processes at which the medical respite program must evaluate an individual's need for reasonable accommodation.

18. Comment Summary: The Department of Health should expand section 1007.5 Required Services to include transferring a recipient to assisted living or a long-term nursing facility if the client is not appropriate for an emergency shelter or independent housing.

Comment Response: The Department considers this part of the assessment, reassessment, care coordination, and discharge requirements outlined in the regulations. Additional details regarding specific assessments are provided in guidance.

19. Comment Summary: Section 1007.5 should also include a requirement to coordinate the delivery of hospice and palliative care services for people at the end of life who do not want to remain in, or are not appropriate for, a hospital setting.

Comment Response: The Department considers this part of the assessment, reassessment, and care coordination requirements outlined in the regulations. Additional details regarding care coordination are provided in guidance.

20. Comment Summary: Section 1007.5 should specify a process to discharge to shelter, if no other placement is available after exhaustive efforts, that includes review of a referral form with medical and ADL information by the shelter system.

Comment Response: The Department considers this part of the assessment, reassessment, care coordination, and discharge requirements outlined in the regulations. Additional details regarding specific discharge requirements are provided in guidance.

21. Comment Summary: The Department of Health should consider allowing recipients to stay in medical respite until they have an appropriate housing placement. If Medicaid is not able to pay for longer lengths of stay, the Department of Health should encourage respite providers to find other funding streams and should call upon hospitals and managed care organizations to make these investments in the long-term wellbeing of recipients, as discharging an individual in the middle of a housing application can jeopardize the success of the housing placement.

Comment Response: Medical respite program length of stay will be further clarified in guidance. However, nothing in regulation precludes an entity from using other sources of funding to allow individuals to continue to reside at the facility when they have exhausted the length of stay allowed under Medicaid.

22. Comment Summary: The Department of Health should consider easing the required timeframe for advance written notice of discharge, from 14 days to 7 days. The guidance document should recommend providers give as much notice as possible while the regulations should require a minimum of 7 days.

Comment Response: The 14-day timeframe, in addition to allowing adequate time for care coordination across multiple entities, allows the recipient time to appeal and request aid continuing before they leave the medical respite program. The Department seeks to avoid situations where medical respite recipients are discharged and then granted the right of return, space permitting, if they timely request aid continuing. The rights for advanced notice, fair hearing, and aid continuing are consistent with other Medicaid and social service programs.

22. Comment Summary: The proposed regulations indicate that a recipient may be involuntarily discharged from medical respite if they pose a risk of harm to self or others "as determined in the reasonable discretion of the medical respite program operator." The Department of Health should instead identify specific criteria based on standards used by hospitals to determine whether an individual should be admitted due to risk of harm to self or others.

Comment Response: The standards used by hospitals to determine involuntary or voluntary admission to an inpatient setting due to risk of harm to self or others would not be appropriate to apply to a medical respite setting as medical respite programs do not have facilities or medical personnel equivalent to a hospital. As stated in section 1007.7(a)(6), a recipient who requires hospital-level care is not appropriate for medical respite services. Sub-regulatory guidance specifies that a recipient may be involuntarily discharged if behaving in a manner that “poses an imminent risk of death or physical harm” to the recipient or others.

23. Comment Summary: If recipients must be involuntarily discharged due to absence from the medical respite program, the maximum allowable time away should be extended from 48 hours to 72 hours. In our experience as a healthcare system, patients who are homeless are extremely medically fragile and may have conditions that require more than 48 hours to resolve.

Comment Response: Section 1007.8(b)(5) of the regulations states that recipients **may** be involuntarily discharged if they have been absent from the medical respite program for more than 48 hours without having complied with the facility's rules concerning absences. In other words, nothing in the regulation requires the facility to discharge a recipient after 48 hours. Further, to be involuntarily discharged due to prolonged absence, the recipient must have failed to comply with the facility's rules concerning absences. Additional information regarding discharge protocols will be provided in sub-regulatory guidance.

24. Comment Summary: The Department of Health should clarify expectations concerning fair hearings. For example, is the recipient expected to remain in medical respite throughout the course of the hearing process, particularly if that process takes 30 days or longer? Would the State pay for the recipient's stay during the hearing process?

Comment Response: All Medicaid members are entitled to request a fair hearing and receive aid continuing, if requested within 10 days of the date of the notice. When aid continuing is requested, Medicaid will continue to pay for the service to be provided until the disposition of the fair hearing. This is clarified in sub-regulatory guidance and consistent with other Medicaid and social services programs.

25. Comment Summary: All recipients, not only those on Medicaid, should have the right to appeal a discharge notice (as is allowed in the shelter system) and request aid to continue while the appeal is pending.

Comment Response: Discharge appeal rights and process will be further clarified in sub-regulatory guidance.

26. Comment Summary: Will a referring hospital be eligible to appeal a discharge notice on behalf of a recipient?

Comment Response: A third party that wants to appeal on behalf of a medical respite recipient would follow the same protocols as for any other Medicaid or social services benefit denial, termination, etc. In order to appeal, the third party must already be listed as an authorized representative with the Department of Health or the recipient's Medicaid managed care organization (MMCO). If the third party is not already listed as an authorized representative, they can either submit an authorized representative form with the appeal or complete the appeal form with the medical respite recipient.

27. Comment Summary: When the patient is ready for discharge from respite, we recommend that medical respite programs be required to involve the referring healthcare systems in the respite discharge planning process.

Comment Response: The proposed regulations require the medical respite program to "coordinate the discharge with...the referring entity or person, as applicable." See 1007.8(a)(4)(iii).

28. Comment Summary: Will the State mandate the exchange of health information?

Comment Response: A signed consent or authorization will be required from the recipient or legal guardian to permit the exchange of health information and other medical respite information, as needed, to determine the recipient's eligibility for medical respite services, coordinate care, process payment, and plan for discharge.

29. Comment Summary: We believe that the Department of Health should provide technical assistance to respite operators to facilitate the appropriate sharing of patient information.

Comment Response: Additional information will be provided in sub-regulatory guidance and in webinars hosted by the Department.

30. Comment Summary: The Department of Health should clarify whether a medical respite operator would be a covered entity that would have access to statewide systems like PSYCKES [Psychiatric Services and Clinical Knowledge Enhancement System].

Comment Response: There may be multiple opportunities for medical respite operators to have access to statewide systems. Access will depend on the facility affiliations and other factors. Additional information will be provided in sub-regulatory guidance.

31. Comment Summary: To the extent legally permitted, we would recommend that any quality improvement reports should also be sent to the healthcare systems funding a medical respite program.

Comment Response: This is already addressed in regulation. The regulations specifically state, in section 1007.9(c), that "Nothing in this subdivision (c) shall be interpreted as prohibiting the operator from sharing the results of the quality improvement process with any other person or entity."

32. Comment Summary: We believe that respite operators should have a special process in place to review deaths that occur in respite facilities.

Comment Response: Incident reports are already mentioned in sections 1007.9(b)(2) and 1007.14(e). Additional requirements regarding the medical respite program's response to death, among other serious incidents, will be provided in sub-regulatory guidance.

33. Comment Summary: The Department of Health should clarify what information must be retained in "records of the maintenance of the physical plant."

Comment Response: This may include contracts, receipts, or other documentation related to facilities maintenance services (e.g., pest control, trash removal). Detailed information will be provided in sub-regulatory guidance.

34. Comment Summary: The Department of Health should clarify the requirements for backup batteries in medical respite programs. Requirements for an emergency power supply should be consistent with those of shelters, and funding should be made available to support providers in meeting this required physical standard.

Comment Response: Technical details of this kind fall beyond the scope of these regulations and will be address in sub-regulatory guidance and Medical Respite program certification application. The Department of Health also plans to host information sessions and training webinars for medical respite programs seeking certification and will highlight requirements for backup batteries at that time, if appropriate.

35. Comment Summary: Given that many people experiencing homelessness have a physical disability that limits their mobility, the Department of Health should edit 1007.12 Physical Standards to include a requirement to meet disability and/or accessibility standards.

Comment Response: Medical respite programs are required to abide by all federal, state, and local laws, regulations, and codes, including those related to individuals with disabilities. As accessibility is already required and individuals with disabilities are protected from discrimination, no additional provision is necessary.

36. Comment Summary: The Department of Health should mandate medical respite facilities to be wheelchair accessible either on all levels or on the first floor.

Comment Response: Medical respite programs are required to abide by all federal, state, and local laws, regulations, and codes, including those related to individuals with disabilities. As accessibility is already required and individuals with disabilities are protected from discrimination, no additional provision is necessary.

37. Comment Summary: The required minimum of one toilet, sink, and shower for every four recipients may not be feasible for medical respite programs that rent their facilities and therefore do not have authority to make substantial changes to building infrastructure. The Department of Health should consider easing these requirements.

Comment Response: These facility requirements are based on feedback received during the first public comment period, and other stakeholders expressed approval of the facility requirements during the current comment period. The regulations otherwise envision that many types of spaces could be used to satisfy the requirements and achieve the goal of providing a space for rest and recuperation.

38. Comment Summary: While we agree that two means of egress from each patient floor is a best safety standard, many older buildings do not have two means of egress from each floor. We recommend that there be flexibilities for older buildings.

Comment Response: These facility requirements are consistent with other laws, regulations, and codes. The Department will provide additional information about acceptable means of egress in sub-regulatory guidance.

39. Comment Summary: We would like further clarification on whether fire escapes are considered a means of egress.

Comment Response: Fire escapes may be considered a means of egress if certain requirements are met; the Department will provide additional details in sub-regulatory guidance.

Comments Submitted in Support of The Revised Rule Making.

40. Comment Summary: Our experiences delivering medical respite services has confirmed our support for a regulatory framework for operators of this essential service model. We commend the state's effort to establish a certification process and to develop standards for this model, which will help to promote the quality of care for individuals recovering from significant medical conditions.

41. Comment Summary: NYC H+H applauds the State's efforts to ensure that medical respite programs will identify and facilitate access to housing for patients.

42. Comment Summary: We support language to define the development and assessment of recipient service plans to inform 1007.7 Eligibility and Admission and 1007.8 Discharge Planning, which will improve the care coordination between hospitals and respite programs and help ensure appropriate resident support.

43. Comment Summary: We acknowledge that the State has adjusted the proposed regulations in response to our request for greater clarity on various topics, including program eligibility, qualifying medical conditions, ability to perform activities of daily living, documentation requirements, language accommodation requirements, and service plan development.

44. Comment Summary: We thank NYS DOH for their updates to section 1007.7 Eligibility and Admission and 1007.12 Food Service that further specify the medical accommodations that are appropriate for a medical respite program setting, including the provision of medically tailored meals and on-site medication storage.