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 Proposed Rule Making for the NYS Medical Respite Program was initially published in the State Register on October 19, 2022 (Medical Respite Program Regulations). During the public comment period (10/19/2022 to 12/19/2022) for the Notice Proposed Rule Making, the Department of Health (the "Department") received comments from individual advocates for the NYS Medical Respite Program; Alliance for Positive Health; Buffalo City Mission; Finger Lakes Performing Provider System; Institute for Community Living; IPH (Interfaith Partnership for the Homeless); National Health Care for the Homeless Council; NYC Health + Hospitals; NYS OMH (Bureau of Inspection and Certification); NYU Grossman School of Medicine, Health and Housing Lab; The Health & Housing Consortium, Inc.; The Legal Aid Society, Homeless Rights Project and on behalf of Coalition for the Homeless.

The New York State Department of Health (NYSDOH) received over one hundred comments from members of the public. All comments received were reviewed and evaluated.
Based on the comments received, revisions were made to the Proposed Rule. A summary of the comments received and the Department's revisions to the Proposed Rule are below:

Comment: Commenters requested clarification on basic program definitions including inspection, eligibility criteria and service plan.

Response: Section 1007.2 Definitions was amended to provide affected parties with notice of statutory authority and clarify the meaning of inspection in subdivision (d); clarifies that

recipient should not require hospital inpatient, psychiatric inpatient, observation unit or emergency room level of care (subdivision (g)(2)) and clarifies definition of service plan in subdivision (g)(3)(ii).

Comment: Commenters requested clarification on the certification and inspection process.
Response: Section 1007.3 Certification; Operating Certificate and Inspection was amended to include the recertification requirement every 5 years in subdivision (a)(1)(i). Clarifies inspections in subdivision (b)(1).

Comment: Commenters expressed concern over resident confidentiality and the safe keeping of records.
Response: Section 1007.4 General Provisions was amended to include definition of confidentiality and release of records in subdivision (c).

Comment: Commenters expressed concern that requiring a 24/7 onsite medical staff, would be burdensome and pose a financial barrier to programs.
Response: Section 1007.6 Personnel was amended to align with program needs of having at least one manager available onsite or by telephone 24 hours a day, seven days a week in subdivision (a)(2).

Comment: Commenters requested clarification on eligibility and admission relating to the ability of a resident to perform ADL's, required referral documents, and language access.

Response: Section 1007.7 Eligibility and Admission was amended to further clarify program eligibility criteria by adding subdivision (a)(2), qualifying medical condition for which an individual requires temporary rest and recuperation; and ability to perform activities of daily living (ADLs) in subdivision (a)(3); subdivision (b) was amended to further define required documentation in (b)(3), add detail to Admission Agreement in (b)(4), clarify individual need for language assistance in (b)(5) and further define Service Plan development and review in subdivision (d).

Comment: Commenters expressed concern for the discharge process, required discharge documents, fair hearing rights and the coordination of discharge with other entities or persons.
Response: Section 1007.8 Discharge. Discharge Planning subdivision (a)(1) was amended to further clarify when a recipient may be discharged; expectation of warm handoff and coordination with new discharge location in subdivision (a)(2) and required Discharge Summary in subdivision (b). Further clarification was added to Discharge in subdivision (d) including fair hearing rights in (d)(2), discharge process to include 14 days advance written notice in (d)(3)(i), and procedure for Involuntary Discharge in (d)(6).

Comments: Commenters expressed concern that residents should have access to and knowledge of program's code of conduct, facility rules and rights prior to admissions.
Response: Section 1007.11 Recipient Rules was amended to clarify the documents that must be provided to recipient prior to admissions in subdivision (b) which include a copy of the medical respite program's code of conduct, facility rules, and recipient's rights.

Comment: Commenters expressed overall concern for adequate capacity, program safety, provisions, and accommodations available for residents to ensure successful recuperation.

Response: Section 1007.12 Physical Standards was amended to clarify in subdivision (d)(3) that recipients will not be engaged with work or cleaning of facility. Additional modifications of 1007.12 include necessary lighting in all spaces in subdivision (d)(4), provision of pillows in subdivision (e)(3)(i), menstrual products in subdivision (e)(3)(v), fans in subdivision (e)(10), laundry accommodations in subdivision (e)(11), no cost telephone calls in subdivision (e)(12), high-speed internet in subdivision (e)(13), medication refrigeration in subdivision (e)(14). Space requirements in subdivisions (h)(2)(i) and (h)(3)(ii) were modified to limit the number of recipients that share bedrooms, toilets, sinks, tubs, and showers.

Comment: Commenters requested clarification about record keeping and related confidentiality.

Response: Section 1007.14 Records was amended to clarify the Recipient Records in subdivision (c), Program Records in subdivision (e) and general Records Retention in subdivision (f) that an operator must maintain; clarified that records may only be accessed for respite services or emergency services.

ASSESSMENT OF PUBLIC COMMENTS

1. **Comment Summary:**

   1007.12a(3): If the facility or portion of the facility has to be used exclusively for respite, this would appear to exclude the possibility of shelter-based medical respite programs, which have been very successful in other places in the US.

   Comment Response:

   Section 1007.12(a)(3) states: "a dedicated portion of the facility must be used exclusively to operate a medical respite program." The "portion of the facility" allows a respite program to operate within a shelter but requires a dedicated space within the shelter to ensure that the recipient has privacy and a space to receive health care and support services.

2. **Comment Summary:**

   The Department of Health should clarify what the potential outcomes would be both for operators and residents of active medical respites that do not receive certification.

   Comment Response:

   Medical respite certification is required for the medical respite program to receive reimbursement for medical respite services from NYS DOH or a Medicaid Managed Care plan. An uncertified medical respite provider may be reimbursed by other third-parties who do not require certification.

   Certified medical respites may elect to provide certain medical services such as medication adherence and administration, and/ or, assistance with activities of daily living.

3. **Comment Summary:**

   We are seeking clarification as to whether both licensed and non-licensed emergency shelters could provide temporary housing in the program.

   Comment Response:

   Any entity that meets the certification requirements may be certified to provide medical respite program services.

4. **Comment Summary:**

   The Department of Health should consider certifying for-profit corporations to expand participation and resources.

   Comment Response:

   The statute only permits not-for-profit corporations to operate medical respite programs. Any change to this would require a statutory change and cannot be addressed through regulatory notice and comment. Any other entity, such as a public benefit corporation or municipality, interested in providing medical respite could contract with a not-for-profit corporation to operate a medical respite program.

5. **Comment Summary:**

   We also recommend adding language that any NYS inspection report and potential corrective action plans be shared with all funders of the medical respite programs, not just the not-for-profit corporation operator.

   Comment Response:

   The certification, inspection, and surveillance process has been clarified in the regulations and will be further clarified in guidance.

6. **Comment Summary:**

Inspections (Section 1007.4, pg. 7): Would the certifications be conducted by the State akin to current CON related surveillance?

Comment Response:

We have revised the regulations to include a definition of inspection and clarified the certification, inspection, and surveillance process, which will be further clarified in guidance.

7. **Comment Summary:**

Will there be a public comment period for the program or an opportunity to give feedback on program design/funding? What is the timeline for implementation of the program?

Comment Response:

Only rulemaking is subject to a formal public notice and comment period. DOH plans to host a series of webinars and medical respite program information sharing sessions for MCOs, medical respite providers, and interested stakeholder groups, on aspects of the program.

8. **Comment Summary:**

Is there no cap to the number of beds in a medical respite program?

Comment Response:

No. There is no limit to the number of beds in the regulations.

9. **Comment Summary:**

Is there a provision for medical respite programs to be operated by entities other than nonprofits?

Comment Response:

No. The statute only permits not-for-profit corporations to operate medical respite programs. Any change to this would require a statutory change and cannot simply be addressed through regulatory notice and comment. Any other entity, such as a public benefit corporation or municipality, interested in providing medical respite could contract a not-for-profit corporation to operate a medical respite program.

10. Comment Summary:

The Department of Health should provide training to not-for-profits to learn how to bill Medicaid for services if applicable.

Comment Response:

Additional guidance on reimbursement and billing will be provided by DOH.

DOH is planning to provide webinars/trainings to all stakeholders, including, not-for-profits, Medicaid Managed Care plans, and hospitals.

11. Comment Summary:

What is the role of the hospital? Do hospitals need to invest and establish contracts with a medical respite provider to access beds for their patients?

Comment Response:

The regulations do not govern the hospital; a hospital may, but is not required to, invest or contribute to the costs of operating, a medical respite program. Expectations regarding the hospital's obligations when they refer to a medical respite program will be set forth in guidance.

12. Comment Summary:

The Department of Health should clarify in regulation the use of facility transportation for residents and who will be providing the transportation.

Comment Response:

Medical respite programs are not required to provide transportation for its recipients. Medical respite programs will be required to arrange for non-emergency medical transportation consistent with Medicaid coverage of NEMT and any other local programs providing transportation (access-a-ride, etc.)

13. Comment Summary:

The Department of Health should clarify in regulation what food service means and if staff will provide food or make arrangements via a third party for food service. MTM is recommended.

Comment Response:

Section 1007.10(b) states "meal service may be provided directly or through contractual arrangements." And, Section 1007.10(c) states "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. " It is up to the medical respite provider to determine whether directly, through contractual arrangements or through a combination that they will meet the food requirement. Nothing in the regulations precludes utilization of medically tailored meals to meet the nutritional needs of recipients that qualify for medically tailored meals."

14. Comment Summary:

The Department of Health should clarify food service and how it will meet medical needs. Commenter recommend additional language be added to clarify that medical respite meals must meet patients' medical dietary restrictions.

Comment Response:

We have added additional clarification to the regulation to make clear that dietary restrictions must be accommodated. We have revised section 1007.10(a) was modified to state "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."

15. Comment Summary:

Quality Improvement reports should be made publicly available when possible.

Comment Response:

Nothing in the regulations precludes an operator from providing the results of the quality improvement process to any other person or entity. We have added a provision to Section 1007.9(c) to clarify.

16. Comment Summary:

The regulations in place would cause operational and funding issues due to building modifications, technical/data reporting training and staff knowledge/time needed to maintain the regulations.

Comment Response:

Most of the facility and records requirements are similar to the requirements imposed on shelters, and therefore, we do not believe that significant modifications to record keeping

practices should be necessary. DOH intends to provide a toolkit to be used by applicants that contains templates of certain required documents and provide training webinars to applicants.

17. Comment Summary:

Furthermore, we strive to achieve the highest level of privacy for our patients, and the requirements address extensive data sharing tasks that could compromise this standard.

Comment Response:

We have revised Sections 1007.8(c), 1007.14(c) to incorporate medical respite program's obligations to maintain the privacy, security and confidentiality of recipient records and information.

18. Comment Summary:

The Department of Health should clarify in regulation that residents are not expected or encouraged to do housework to maintain their residence. Staff must complete housework and ensure cleaning products are not accessed by residents.

Comment Response:

We agree. We have revised section 1007.12(d)(3) to remove the reference to a recipient performing work and this now states: "Recipients must not have access to storage areas used for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous or flammable materials."

19. Comment Summary:

The Department of Health should clarify in regulation that residents are allowed to request more than one pillow if it will assist in their comfort and recovery. Staff must provide an additional pillow to residents when requested for their comfort and recovery.

Comment Response:

We revised Section 1007.12(e)(3)(i) to include pillows in the list of supplies that must be provided in sufficient quantity to address the needs of the recipient.

20. Comment Summary:

The Department of Health should change in regulation, “feminine hygiene products” at Proposed § 1007.12(e)(3)(v) to “menstrual products”. Language used should be inclusive to all gender types.

Comment Response:

Section 1007.12(e)(3)(v) was modified to state: "menstrual products."

21. Comment Summary:

The Department of Health should allow respites to request their own set amount of start-up funding based on their members served and financial program needs.

Comment Response:

Start-up funding for medical respite entities goes beyond the scope of the regulations. DOH will be providing additional information regarding any funding opportunity for qualified medical respite programs in a separate document.

22. Comment Summary:

How will the medical respite program be funded on a recurrent basis?

Comment Response:

Payment for medical respite program services goes beyond the scope of the regulations. DOH will be providing additional information regarding any funding availability for medical respite programs and payment for medical respite program services.

23. Comment Summary:

How will billing work for the program, and what is the role of the MCO? What are the criteria and reimbursement codes for services provided in respite e.g., medically tailored meals, etc.?

Comment Response:

Payment for medical respite program services goes beyond the scope of the regulations. DOH will be providing additional information regarding the funding available for programs and payment for medical respite program services. Relevant rate codes, rates and other billing requirements shall be set forth in DOH guidance.

24. Comment Summary:

The Department of Health should clarify in regulation that additional funds can be used for the housing application process.

Comment Response:

Nothing in the regulations or sub-regulatory guidance prohibits medical respite programs access to or use of any third-party funding or requires medical respite programs to use third-party funding or Medicaid managed payments to cover specific operational costs.

25. Comment Summary:

The Department of Health should allow respites to engage in a net deficit contract to bill MCOs for undocumented individuals or returns to the hospital.

Comment Response:

Expectations for bed holds for recipients who temporarily leave a medical respite facility are clarified in regulations. Medical Respite is only available for Medicaid members enrolled in Medicaid Managed Care plans. Undocumented individuals are currently

ineligible for Medicaid Managed Care plans (unless pregnant/post-partum or some children over 18). Accordingly, undocumented individuals not enrolled in Medicaid Managed Care plans are ineligible Medical Respites may hold outside contracts or funding streams to assist this population.

26. Comment Summary:

The Department of Health should allow respites to bill an enhanced rate for various services.

Comment Response:

Payment for medical respite program services goes beyond the scope of the regulations. DOH will be providing additional information regarding the funding available for medical respite programs and payment for medical respite program services. A medical respite program may negotiate enhanced rates with Medicaid managed care plans. Some of these services already may be covered under recipients' Medicaid managed care benefits.

27. Comment Summary:

We also recommend that the State consider developing a framework that allows the medical respite provider to share in the value delivered (i.e., potential savings to the hospital system).

Comment Response:

Nothing in the regs or guidance prohibits the potential for a medical respite program to participate in VBP contracts with MCOs and/or hospital systems.

28. Comment Summary:

To ensure access to this important newly licensed service for all Medicaid insured individuals, it is essential that Medicaid Managed Care plans be required to contract with all licensed service provider in a timely fashion at the State Medicaid rate or a mutually agreed alternative.

Comment Response:

Medicaid managed care contracting is beyond this scope of these regulations. Medicaid managed care plan obligations will be addressed in the Medicaid managed care plan contracts and the NYHER 1115 waiver, as well as DOH guidance.

29. Comment Summary:

Expand on the roles of managed care organization and health system partners in determining eligibility, collaboration, and billing with medical respite providers.

Comment Response:

This will be addressed in the sub-regulatory guidance on eligibility.

30. Comment Summary:

The Department of Health should require in regulation for respites to have air conditioner and air filtration systems in addition to heating and fans.

Comment Response:

Medical Respites will be required to provide air conditioners. In instances of extreme heat, a fan may not be sufficient.

31. Comment Summary:

Will local building codes and zoning codes be applicable to the establishment of medical respite programs?

Comment Response:

Yes, local building and zoning codes must be adhered, as stated in Section 1007.12(a)(1).

32. Comment Summary:

The Department of Health should further define in regulation the location of "emergency stations". Staff must post evacuation instructions on each floor and wing about the "emergency stations". Staff must also provide evacuation assistance to those with accessibility limitations.

Comment Response:

Section 1007.12(c)(7) was modified to state: "areas of refuge"

33. Comment Summary:

Section 1007.12 Physical Standards 1007.12b(2)(i) - Does “emergency power supply”, mean a generator?

Comment Response:

The emergency power supply shall be in the form of backup batteries, not required to be generators.

34. Comment Summary:

The Department of Health should clarify in regulation that staff must make a telephone(s) available to residents for both incoming and outgoing calls. Staff must also provide free internet to residents on both on a computer(s) and their personal devices if applicable.

Comment Response:

We appreciate your comment and have revised Section 1007.12(e)(12) to state: "A telephone or telephones must be available for recipient to use and receive calls at no cost to the recipient." Section 1007.12(e)(13) was revised to state: "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)."

35. Comment Summary:

The Department of Health should clarify in regulation clauses and guidelines to ensure a fair discharge process from the respite. The discharge process provided by the respite facility must be democratic, provide written notices to the resident and allow the resident to dispute a determination for discharge. Specifically, circumstances surrounding a resident's violent or disruptive behavior should be addressed.

Comment Response:

The Medical respite will use the Medicaid fair hearing process (18 NYCRR Part 358) for hearing notices, appeals and related discharge disputes.

36. Comment Summary:

Section 1007.12 Physical Standards 1007.12a(2): How is “appropriate” defined and/or who determines “appropriate” for a facility? We hope this is a protective measure in that recipients with mobility devices/needs are not referred to medical respite programs that only have stairs.

Comment Response:

Appropriate assessment criteria will be clarified in sub-regulatory guidance on eligibility. All medical respite programs are required to comply with all federal, state, and local laws, including the ADA.

37. Comment Summary:

Add “adequate lighting in all spaces” as a falls prevention measure.

Comment Response:

Section 1007.12(d)(4) was changed to state: "Lighting must be adequate in all spaces. Night lights must be provided and working in all hallways, stairways and bathrooms which are not private."

38. Comment Summary:

Older buildings may not meet all of the listed physical standards, such as an emergency power supply (1007.12b(2)(i)) and two means of egress (1007.12c(3)),and will require discussions with Facilities Management.

Comment Response:

The emergency power supply shall be in the form of backup batteries, not required to be generators. The egress requirements are consistent with shelter regs at 18 NYCRR 491.18.

39. Comment Summary:

The Department of Health should clarify in regulation where and how paper and electronic records are to be stored by staff.

Comment Response:

We have clarified in the regulations that records may be maintained in hard or electronic copy. Certain records as indicated in the regulations must be kept at the facility. Further guidance on record maintenance and retention will be provided in the sub-regulatory guidance on facilities.

40. Comment Summary:

The Department of Health should mandate respite programs to provide either single or double rooms to all recipients. Additionally, bathrooms should be shared with no more than four people

Comment Response:

We agree. Section 1007.12(h)(3)(ii) was revised to state: "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." Section 1007.12(h)(2)(i) was revised to state: "There shall be a minimum of one toilet and one sink for each four recipients, and one tub or shower for each four recipients."

41. Comment Summary:

The Department of Health should clarify what constitutes a “main internal communication capability, including nurses’ call systems”.

Comment Response:

Section 1007.12(b)(2)(ii) was changed to state: "fire alarm system"

42. Comment Summary:

The Department of Health should consider flexibility and additional planning for older buildings.

Comment Response:

Facility requirements are consistent with shelter regulations at 18 NYCRR 491.18; and where they are not, they are being revised to accommodate the unique needs of recipients and medical respite services.

43. Comment Summary:

The Department of Health should mandate respites to be wheelchair accessible either on all levels or the first floor.

Comment Response:

This would be cost prohibitive for some medical respite programs and may not be possible in some buildings. All medical respite programs must comply with all applicable federal, state, and local laws, including ADA. This concern is being addressed in guidance on recipient rights and acceptance.

44. Comment Summary:

Will admissions have to be directly (Discharged or Diverted) from a hospital? If not will preference be given to individuals being discharged from a hospital?

Comment Response:

Nothing in the regulations precludes other entities from referring to medical respite programs. This will be further clarified in sub-regulatory guidance on eligibility and acceptance.

45. Comment Summary:

In order to determine eligibility, medical respite programs must have a clearly defined meaning of what "minimal assistance" means in regulation. This will ensure a standard in terminology across NYS.

Comment Response:

Minimal assistance is defined in regulation as, “needing at least limited assistance with physical maneuvering with more than two activities of daily living.”

46. Comment Summary:

1007.7b(1): How do medical respite programs account for conditions that emerge after a recipient has been admitted into medical respite?

Comment Response:

To ensure that recipient's needs are adequately addressed, Section 1007.7(d) has been revised to require a reassessment at least every two weeks. The revised provision states: "…and revise the service plan as needed based on the recipient's reassessment which shall be performed, as needed, but no less than every two weeks to ensure the recipient's needs are addressed in the current service plan."

47. Comment Summary:

The Department of Health should require in regulation for staff to seek both a housing referral and ensure the placement is accepted prior to discharging the resident. This discharge plan should also require staff to provide accessible transportation of the resident and their belongings to the new housing.

Comment Response:

Section 1007.8a(2) has been added to the provision to state that "…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. However, nothing in the regulations precludes an entity from using other sources of funding to allow people to continue to reside at the facility when they no longer qualify for medical respite reimbursement from DOH.

48. Comment Summary:

1007.7a(3): What does "self-directing" mean? How is this determined? 1007.7a(3): Remove mention of "self-directing" and replace it with: "The individual is capable of making choices about the individual's activities of daily living…"

Comment Response:

Self-directing has been clarified in Section 1007.7(a)(4) to read as "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".

49. Comment Summary:

NYSDOH should develop and oversee an appeals process for recipients who disagree with their discharge plan.

Comment Response:

The Medical respite will use the Medicaid fair hearing process (18 NYCRR Part 358) for hearing notices, appeals and related discharge disputes.

50. Comment Summary:

1007.7b(3): What type of documentation is required? Is the referring agency or respite provider responsible for documenting the need for medical respite services?

Comment Response:

This will be addressed in the sub-regulatory guidance on eligibility and admission.

51. Comment Summary:

1007.7b(4)(iii) - If a recipient stays longer than 30 days, will there be tenancy issues?

Comment Response:

No, this is addressed in Section of 4 of New York Public health Law 2999-hh.

52. Comment Summary:

1007.7b(1): Add to end of sentence, “directly or facilitate the provision of those services.”

Comment Response:

The requested edit does not seem to appear relevant to the section cited.

53. Comment Summary:

How will staff determine a resident is healthy for discharge to a shelter?

Comment Response:

Medical respite program is meant to be a temporary residential program for homeless individuals and those at risk for homelessness. As such, medical respite programs shall discharge recipients when they no longer qualify for medical respite services, as defined in Section 1007.7(a) of the regulations. Additional sub-regulatory guidance will be issued by DOH.

Comment Summary:

1007.8a(1): What does “no longer needing medical respite” mean? How is this determined, and who is responsible for making this determination?

Comment Response:

This will be addressed in the sub-regulatory guidance on discharge.

54. Comment Summary:

1007.8a(1): Does work on a housing application count as an ongoing need for medical respite services? The recommendation is to include this as an ongoing need.

Comment Response:

We have revised this provision to state "when they no longer qualify for medical respite" and added Section 1007.8a(2) to the provision to state that "…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." However, nothing in the regulations precludes an entity from using other sources of funding to allow people to continue to reside at the facility when they no longer qualify for medical respite reimbursement from DOH.

55. Comment Summary:

1007.8a(3)(ii): What does "advanced notice" mean? How is this determined in terms of timeline?

Comment Response:

We have revised section 1007.8a(4)(ii) to read as "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).

Comment Summary:

The Department of Health should clarify the goal of discharge is permanent housing. If a resident is discharged to an unsheltered location, it should prompt a review or audit by Department of Health.

Comment Response:

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. When a recipient no longer qualifies for medical respite, because they have recovered or healed or they are no longer eligible for Medicaid reimbursement for medical respite services, they can be discharged without a permanent housing placement. Given the importance of permanent housing, the following language has been added to section 1007.8(a) "If housing has not been identified when the recipient is ready for discharge, all housing packets and applications should be transferred to the discharge location, which has agreed to continue to assist the recipient with securing permanent housing."

Annual Report and associated required notification to NYS DOH will be provided in guidance.

56. Comment Summary:

Recommendations 1007.8a(1): Add to the end of sentence, “as described in Section 1007.5a(3) Care Coordination Services.”

Comment Response:

The following clarifying language was added to Section 1007.8: "as defined in section 1007.7(a)."

57. Comment Summary:

Recommendations 1007.8a(3): Add a requirement to obtain recipient consent.

Comment Response:

We have revised the regulations in several places to clarify the operator's obligations to maintain the privacy, security and confidentiality of recipients' and information, while balancing the need for operators to share information for the recipients' access to services.

58. Comment Summary:

Recommendations 1007.8a(3)(ii): Add "referring agency and discharge location (e.g. shelter or housing provider, family, etc.)" to list of those needing notice of discharge.

Comment Response:

We have revised Section 1007.8(a)(4) to include "referring entity or person, discharge location."

59. Comment Summary:

Recommendations 1007.8a(3)(iii): Add to the end of sentence, "and discharge location (e.g. shelter or housing provider, family, etc.)."

Comment Response:

We have revised Section 1007.8(a)(4) to include "referring entity or person, discharge location."

60. Comment Summary:

The Department of Health should clarify in regulation that staff will have limited access to a resident's full medical health record and limited abilities to assist with medical care.

Comment Response:

The language in section 1007.8(b) related to a discharge summary was changed to add "to the extent known" to anything that medical respite programs may not have been provided or information that may be otherwise unknown by the medical respite program. Additional clarification regarding medical respite program's expectations to collect or obtain certain information will be provided in sub-regulatory guidance on discharge.

61. Comment Summary:

Section 1007.11 Recipient Rules. Recommendations 1007.11: Add the requirement that recipients sign an agreement with the program that acknowledges their receipt and agreement with the code of conduct and other program rules (as mentioned in Section 1007.7 Eligibility and Admission).

Comment Response:

We agree; Section 1007.11(b) was revised to require the recipient to sign an acknowledgement they received this information and to receive a copy.

62. Comment Summary:

The Department of Health should clarify what the requirements are for hospital care coordination, assessments and service plans for physical health needs, mental health needs, and substance use needs.

Comment Response:

The definition of service plan in section 1007.2(i) was changed to include "… the recipient's physical health, mental health, substance use, and supportive service needs."

63. Comment Summary:

The Department of Health should clarify what the maximum length of stay is per visit and/or annually.

Comment Response:

Length of stay will be dependent on how long the recipient meets the eligibility criteria for respite as set forth in section 1007.7(a). However, we expect the average length of stay to be around 30 days. Any minimum/maximum length of stay criteria will be further clarified in sub-regulatory guidance.

64. Comment Summary:

Under 1007.7 Eligibility and Admissions and 1007.8 Discharge Planning, provide more guidance to help programs determine and document when a recipient may be deemed eligible for admission and discharge in accordance with care outlined in Section 1007.5 Required Services.

Comment Response:

This will be addressed in the sub-regulatory guidance on discharge.

65. Comment Summary:

Will there be any ratio of licensed medical staff FTE's to residents?

Comment Response:

Staffing requirements, including qualifications and training, will be addressed in sub-regulatory guidance.

66. Comment Summary:

Is DOH using income limits and/or current definitions of homelessness, housing insecurity, and at-risk-of-homelessness to determine eligibility?

Comment Response:

As a Medicaid service, it is not restricted to only those who qualify for PA/TANF and will be available to any Medicaid-member in a mainstream Medicaid managed care plan who is unhoused or at risk of homelessness. The definition of homelessness is included in the enabling statute, PHL 2999-hh: "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; provided, however, that an operator of a medical respite program shall be permitted to specialize by providing services to a subpopulation of homeless recipients if necessary to respond to community need or 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 made pursuant to this section." PHL 2999-hh.

67. Comment Summary:

Are Medicaid sanctioned individuals eligible for the program?

Comment Response:

Sanctions are typically not placed on Medicaid members. Any eligible Medicaid member will have access to covered medically necessary services.

68. Comment Summary:

The Department of Health should define requirements of care and eligibility for residents with underlying behavioral and substance abuse issues.

Comment Response:

The regulations have been changed to state that medical respite programs may consider behavioral health and substance use disorders more explicitly.

69. Comment Summary:

Can homeless individuals in the community be screened for medical respite services thereby potentially avoiding hospitalization and ED visits?

Comment Response:

The regulations do not restrict referral sources to medical respite programs.

70. Comment Summary:

How will the medical respite program assist the families/dependents of a resident in the medical respite?

Comment Response:

The medical respite program, as designed, is intended for adults who would reside alone until their condition improved.

71. Comment Summary:

Eligibility and Admission (Section 1007.7, pg. 10): Although the proposed regulations outline self-direction requirements, minimal assistance with ADLs would benefit from further definition and elaboration.

Comment Response:

This will be addressed in sub-regulatory guidance on eligibility and admissions.

72. Comment Summary:

We recommend that the medical respite program work with local shelters to attempt discharge to shelter and not the streets, whenever placement to shelter is possible.

Comment Response:

We would expect medical respite programs to work with shelters as part of their discharge planning process. This will be addressed in sub-regulatory guidance on discharge.

73. Comment Summary:

The medical respite should obtain consent to send the discharge plan to the new referred shelter prior to discharge.

Comment Response:

We have revised the regulations in several places to clarify the operator's obligations to maintain the privacy, security and confidentiality of recipients' and information, while balancing the need for operators to share information to facility the recipients' access to services.

74. Comment Summary:

Patients should be eligible for respite prior to and after hospital admissions.

Comment Response:

Anyone who meets the eligibility criteria and is enrolled in a mainstream managed care plan may be eligible for services, if space is available in a facility. There is no eligibility criteria that requires a medical respite program recipient to have been previously in an inpatient setting to qualify. This will be further clarified in sub-regulatory guidance.

75. Comment Summary:

Commenter noted that, non-health care entities would not have the necessary clinical information to be a referral source for respite services.

Comment Response:

Anyone who is assessed by the medical respite program to meet the eligibility criteria and be appropriate for medical respite can receive medical respite. There is nothing in the regulations that preclude a shelter, community-based organization, or other non-clinical entity from referring a prospective recipient for assessment. This will be further clarified in sub-regulatory guidance.

76. Comment Summary:

The Department of Health should provide potential definitions for subpopulations deemed to be eligible for the program by the medical respite.

Comment Response:

As indicated in the regulations, a medical respite program may serve a subpopulation of recipients due to limitations imposed by funders, i.e. if the funder's have required the program to service only persons who have certain conditions or limitations.

77. Comment Summary:

The medical respite should coordinate discharge plan with the hospital to ensure it is followed.

Comment Response:

Section 1007.8(a)(4)(ii) has been changed to include the referring entities in coordinating the discharge planning. As referral for medical respite is not limited to hospitals, a broader term has been used.

78. Comment Summary:

Where do medical respite programs fit in the continuum of care among existing facilities and programs?

Comment Response:

Medical respite program will be temporary residential facilities that arrange for the provision of medical and supportive services to individuals who are homeless or at risk of homelessness, and no longer has an acute need to be in inpatient setting, but has not recuperated enough to be discharged to the streets or shelter. Medical respite entities are not considered medical facilities, nor residential/shelter facilities, but exist somewhere between the two continuums.

79. Comment Summary:

The Department of Health should clarify in regulation that staff must notify residents about their ability to provide feedback/complaints about the program. The Department of Health should make available direct reporting for residents that want complaints reviewed beyond the medical respite.

Comment Response:

The medical respite recipients will use the established Medicaid fair hearing process (18 NYCRR Part 358) for hearing notices, appeals and related discharge disputes.

80. Comment Summary:

Staff must be able to drive and operate vehicles that have mechanisms for wheelchairs, general accessibility, etc. to accommodate persons with disabilities. DOH must define this in regulation.

Comment Response:

Medical respite programs are not required to provide transportation for its recipients. Medical respite programs will be required to arrange for non-emergency medical transportation consistent with Medicaid coverage of NEMT and any other local programs providing transportation (access-a-ride, etc.)

81. Comment Summary:

Staff must perform daily wellness checks which will need to be detailed out in both the service plan and in the staff's daily duties. DOH must define this in regulation.

Comment Response:

Section 1007.5(4) has been revised to clarify frequency of wellness checks. Additional information will be provided in guidance.

82. Comment Summary:

Staff must provide vital records, recipient’s rights, and facility rules to a resident when requested, in their preferred language or mode of communication. Staff must be able to discuss the documents, answer questions and ensure the resident understands. Guidelines should be established by DOH in regulation for these requests.

Comment Response:

Section 1007.7(b)(12) was revised to state: "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."

83. Comment Summary:

The Department of Health should revise Proposed § 1007.12(e)(11) to include instructions for facility workers to offer assistance and reasonable accommodations for clients who cannot do their own laundry.

Comment Response:

Section 1007.12(e)(11) has been revised to state: "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." Further clarification will be provided in sub-regulatory guidance.

84. Comment Summary:

DOH must require in regulation for staff to keep any and all records related to a resident including reasonable accommodation requests, discharge notices, appeals, physical evacuation needs and other outcomes in addition to health information and service plans. Staff must provide these documents to the resident upon request in their preferred language and mode of communication.

Comment Response:

Section 1007.14(d)(1)(iii) has been revised to include: "the reasonable accommodation requests, decisions, and fulfillment measures, if applicable." Additional clarification will be provided in sub-regulatory guidance.

85. Comment Summary:

Staff must have experience working the following populations: homeless, medically frail, developmental disabilities.

Comment Response:

We believe the proposed regulations adequately address the requirement that the applicable organizations have experience working with people experiencing homelessness. The sub-regulatory guidance will provide additional guidance on personnel requirements.

86. Comment Summary:

1007.6a(2): Who determines “sufficient number of staff”? For each staff type, are there recommendations for patient-provider ratios or number of staffed hours per day or week?

Comment Response:

There are no staffing ratios, only minimum staffing requirements. Additional staffing information will be provided in sub-regulatory guidance.

87. Comment Summary:

Recommendation 1007.6: Add a requirement of sufficient language competency among staff and/or interpretation services to be provided.

Comment Response:

The sub-regulatory guidance will provide additional guidance on personnel requirements.

88. Comment Summary:

1007.9d(5): Add “as appropriate” after medication storage since this is not a required service under Section 1007.5 Required Services.

Comment Response:

We expect that many recipients will require medication while residing in the facility. Therefore, the medical respite program will need to be able to securely store medication.

89. Comment Summary:

The Department of Health should consider mandating respites to have a licensed social worker (LMSW) and peer specialist available for residents 24/7.

Comment Response:

We have removed the requirement for clinical staff and will be providing sub-regulatory guidance on personnel requirements. A medical respite program is permitted to hire a clinical or peer-support or other staff as necessary for it to meet the needs of the recipients.

90. Comment Summary:

1007.6 Personnel: Clarify the number and type of staff (e.g., clinicians, social workers, health aides, program staff, security, etc.) recommended to be available, either on-site or telephonically.

Comment Response:

We have removed the requirement for clinical staff and will be providing sub-regulatory guidance on personnel requirements.

91. Comment Summary:

Ease medically-focused requirements under sections 1007.6 Personnel and 1007.8 Discharge Planning, as the primary services of medical respite programs focus on rest, recuperation, and care coordination.

Comment Response:

We expect that medical respite programs will receive much of this information as it will be necessary to provide medical respite services; however, we understand that medical respite program may not receive some of the information. Accordingly, the language in section 1007.8(b) related to discharge summary was revised to add "to the extent known" to anything that medical respite programs may not have been provided or information that may be otherwise unknown by the medical respite program.

92. Comment Summary:

The Department of Health should clarify what services and staff the medical respite must directly provide and what services can be completed by a third party.

Comment Response:

The regulations do no prohibit multi-agency collaboration. However, one entity must be accountable from a certification perspective.

93. Comment Summary:

Medical respites must provide services for all various identified needs.

Comment Response:

The regulations have been changed to state that medical respite programs may consider behavioral health and substance use disorders more explicitly.

94. Comment Summary:

The Department of Health should consider peer support as an added value to residents.

Comment Response:

We believe the proposed regulations adequately address the requirement that the applicable organizations have experience working with people experiencing homelessness. The sub-regulatory guidance will provide additional guidance on personnel requirements. A medical respite program is permitted to hire a clinical or peer-support or other staff as necessary for it to meet the needs of the recipients.

95. Comment Summary:

The Department of Health should consider a DSS Liaison for permanent housing assistance after discharge.

Comment Response:

Providing a LDSS liaison is outside the scope of this program, but we would expect that as part of care coordination and discharge planning, medical respite programs would coordinate with LDSS. The need to coordinate with LDSS is incorporated into the sub-regulatory guidance on service plans.

96. Comment Summary:

The Department of Health should consider a Health Home Liaison for assistance after discharge. Staff should be able to determine if a resident is enrolled.

Comment Response:

Medical respite programs are expected to coordinate with a recipient's Health Home program per the regulations.

97. Comment Summary

Personnel (Section 1007.6, pg. 9): We recommend that a trained medical professional (either physician, nurse practitioner, physician assistant, or registered nurse) be available onsite or by telephone 24 hours a day.

Comment Response:

We appreciate your comment but given that the medical respite program is not providing clinical services, we have not made this requested change. A medical respite program is permitted to have a clinical person onsite or available by telephone 24/7 but this is not a requirement.

98. Comment Summary:

Discharge Planning (Section 1007.8, pg. 14): Respite Operators may not have the most up-to-date clinical information necessary to provide a pain management plan, as proposed. We would thus recommend adding language that the pain management plan should originate from the referring clinical care team.

Comment Response:

We expect that medical respite programs will receive much of this information as it will be necessary to provide medical respite services; however, we understand that medical respite program may not receive some of the information. Accordingly, the language in section 1007.8(b) related to discharge summary was revised to add "to the extent known" to anything that medical respite programs may not have been provided or information that may be otherwise unknown by the medical respite program.

99. Comment Summary:

Clinical on-call staff would be a burden for non-profits. They will be using clinical third-party for on-call assistance. It is not necessary to have 24/7 or on-call clinical staff. What type of staff are required to be on-site 24/7?

Comment Response:

Section 1007.6(a)(2) has been revised to state: "At least one manager must be available onsite or by telephone 24 hours a day, seven days a week."