NEW YORK STATE DEPARTMENT OF HEALTH
CERTIFIED MEDICAL RESPITE PROGRAM

Preliminary Guidance for Medicaid Waiver-Funded Services

In January 2024, the Department of Health (Department) adopted new regulations at **10 NYCRR Part 1007** that define certification and operating standards for medical respite programs. The Department also received federal approval for an amendment to New York State's Medicaid section 1115 demonstration waiver. As part of a larger strategy to improve health equity in New York State, the waiver provides for the establishment of regional Social Care Networks (SCNs) that will contract with social care service providers to deliver social care services to eligible Medicaid managed care members. Medical respite, also known as *recuperative care*, is one of several health-related social needs (HRSN) services funded under the terms of the waiver.

- This guidance document applies *only* to medical respite stays that are paid for by a SCN using Medicaid section 1115 demonstration waiver funds (that is, "Medicaid waiver-funded" medical respite stays).
- Medicaid waiver-funded medical respite stays are subject to all requirements identified in:
    - This guidance document;
    - 10 NYCRR Part 1007;
    - *SCN Operations Manual*; **and**
    - Any other medical respite guidance issued by the Department.
- This guidance document will be updated frequently to reflect changes in policy and guidance related to the overall Medicaid 1115 demonstration waiver and the SCNs.

SOCIAL CARE NETWORK AS PAYOR

The SCN will be the payor for Medicaid waiver-funded medical respite services. To receive Medicaid waiver-funded reimbursement for services, the medical respite program must:

- Obtain certification from the Department in accordance with 10 NYCRR Part 1007 and any related guidance issued by the Department.
- Contract with the regional SCN to provide medical respite services.
- Comply with SCN decisions regarding recipient eligibility and allowable length of stay.
    - Note that the medical respite program has primary responsibility for determining the recipient's length of stay; however, the SCN will review and approve or reject this recommendation.

RECIPIENT ELIGIBILITY

To be eligible for Medicaid waiver-funded medical respite services, a recipient must:

- Meet all criteria established in 10 NYCRR §1007.2 and §1007.7 and in the Department's *Guidance on Referrals, Assessments, and Service Plans*;
- Be an enrolled Medicaid managed care member;
- Qualify to receive Enhanced Health-Related Social Needs services (Enhanced HRSN services), as defined in the forthcoming *SCN Operations Manual*; **and**
- Meet the clinical and social risk criteria for medical respite services as defined in the forthcoming *SCN Operations Manual* and authorized by the SCN.

REFERRAL PATHWAY

Typically, the referring provider will refer an eligible member to the appropriate regional SCN, and the SCN will then refer the member to a specific medical respite program. However, other referral pathways are possible depending on the terms of the contract between the SCN and the medical respite program.

LIMITS ON LENGTH OF STAY

Under the terms of the waiver:

- *Post-hospitalization* care is limited to 90 days total per each 12-month period.
- *Pre-procedure* care is limited to a clinically appropriate amount of time as determined by a medical professional and is typically brief in duration. Pre-procedure care is limited to 30 days total per each 12-month period.
- An eligible individual may be admitted to medical respite care multiple times over a 12-month period, as long as:
    - Each admission is clinically appropriate;
    - The individual still meets all criteria listed under "Recipient Eligibility," above; **and**
    - The individual's stay in medical respite does not exceed the time limits specified above (that is, 90 days for post-hospitalization care or 30 days for pre-procedure care).
- In all cases, the 12-month period will be assessed on a rolling basis, not by calendar year.

Nothing in the regulations or guidance precludes another entity (such as a managed care organization, a hospital system, local government, charitable organization, etc.) from paying for a recipient to reside in the medical respite program for additional days beyond the maximum Medicaid waiver reimbursable stay.

APPEALS

Pursuant to 18 NYCRR Part 358, medical respite recipients who are enrolled in the New York State Medicaid Program have the right to appeal a discharge decision. The procedure for filing an appeal varies depending on the payor funding the recipient's medical respite services.

A third party may appeal on behalf of a recipient or help the recipient to submit an appeal request. The third party must be listed as an authorized representative with the Department of Health or the recipient's Medicaid managed care organization. If the third party is not listed as an authorized representative, the third party may either submit an authorized representative form along with the appeal or complete the appeal form with the recipient.