NEW YORK STATE | Department of Health



Social Care Network: Program, Billing, and Data Governance Operations Manual

05/01/2026







TABLE OF CONTENTS

0. UPDATES FROM PRIOR VERSIONS 5

1. GLOSSARY OF COMMON TERMS 13

2. ABOUT THIS OPERATIONS MANUAL 20

3. INTRODUCTION 21

A. VISION AND GOALS FOR SCN PROGRAM 21
B. OVERVIEW OF SCN PROGRAM DESIGN 22
C. OVERVIEW OF SCN REGIONS 24
D. OVERVIEW OF HRSN SERVICES 24
E. OVERVIEW OF ENTITIES IN THE SOCIAL CARE ECOSYSTEM 25

4. SCN INFRASTRUCTURE 28

A. HRSN NETWORK CAPACITY AND ACCESS 28
B. GOVERNANCE REQUIREMENTS 37
C. SCN IT PLATFORM REQUIREMENTS 38
D. TRAINING EXPECTATIONS 46
E. SCN PUBLIC WEBSITE 47
F. PUBLIC MATERIALS ON SCN PROGRAM 48

5. CARE DELIVERY APPROACH 50

A. INTRODUCTION 52
B. SCREENING 53
C. SOCIAL CARE NAVIGATION 62
D. ELIGIBILITY ASSESSMENT 64
E. SCN REFERRALS 91
F. SERVICE RE-AUTHORIZATIONS 99
G. ENHANCED SERVICES MEMBER FILE 101
H. CHANGES IN MEMBER MEDICAID COVERAGE AND RELOCATION 102
I. SOCIAL CARE PLANS 106
J. HRSN SERVICES 114
K. PARTNERSHIPS 210
L. MEMBER CONSENT 213
M. DUPLICATIVE SERVICES 215

6. PERFORMANCE 237

A. OVERALL APPROACH TO PERFORMANCE MANAGEMENT 237
B. SCN LEAD ENTITY REPORTING 240

7. PAYMENTS ..... 261~~262~~

A. INFRASTRUCTURE FUNDING ..... 262~~263~~
B. PMPM PAYMENTS ..... 265~~266~~
C. PAYMENT METHODOLOGY FOR SERVICES DELIVERED ..... 268~~269~~

8. CONTRACT REQUIREMENTS ..... 273~~274~~

A. INTRODUCTION TO SCN CONTRACT REQUIREMENTS ..... 273~~274~~
B. SCN MEDICAID BILLING SOCIAL CARE PROVIDER DESIGNATION AND ENROLLMENT ..... 273~~274~~
C. SCN CONTRACT REQUIREMENTS WITH OHIP ..... 275~~276~~
D. SCN CONTRACT REQUIREMENTS WITH MCOs ..... 277~~278~~
E. MCO CONTRACT REQUIREMENTS WITH OHIP ..... 279~~280~~
F. SCN CONTRACT REQUIREMENTS WITH HRSN SERVICE PROVIDERS AND OTHER ENTITIES ..... 280~~281~~

9. DATA GOVERNANCE, PRIVACY, AND SECURITY ..... 291~~292~~

A. INTRODUCTION ..... 291~~292~~
B. DATA GOVERNANCE FRAMEWORK ..... 292~~293~~
C. DATA PRIVACY AND SECURITY ..... 292~~293~~
D. DATA SHARING - INTEROPERABILITY ..... 296~~297~~
E. DATA SETS, TERMINOLOGIES, AND CODING ..... 297~~298~~
F. DATA AND SYSTEMS IMPLEMENTATION GUIDE (DSIG) ..... 311~~312~~

10. OHIP PRIVACY AND SECURITY REQUIREMENTS ..... 312~~313~~

A. INTRODUCTION ..... 312~~313~~
B. DATA GOVERNANCE FRAMEWORK ..... 312~~313~~
C. DATA PRIVACY AND SECURITY ..... 313~~314~~

11. FEE SCHEDULE ..... 319~~320~~

A. SCREENING ..... 319~~320~~
B. CARE MANAGEMENT ..... 320~~321~~
C. HOUSING ..... 321~~322~~
D. NUTRITION ..... 335~~336~~
E. TRANSPORTATION ..... 341~~342~~
F. APPENDIX ..... 343~~344~~

Social Care Network (SCN) Operations Manual Attachments

All Manual attachments will be made available via SharePoint.

Attachment type	Attachment Name
Agreement templates	MCO-SCN Agreement Template
	SCN-Provider Agreement
Report templates *(For reporting details, see SCN Reporting)*	Quarterly Performance Report
	Weekly Performance Management Report (Operational Indicator Survey)
	Governing Body Report
	Network Composition Plan and Report
	Infrastructure Cost Report
	Budget Reassessment Report
	SCN Instructions Manual for Weekly Operational Indicator Surveys
Other documents	Provider Attestation Form
	Member Experience Survey
	HRSN Service Provider Survey
	Platform Resource Pack

0. UPDATES FROM PRIOR VERSIONS

The New York State Office of Health Insurance Programs (OHIP) seeks to maintain an up-to-date SCN Operations Manual to guide SCNs and other stakeholders during the lifetime of the SCN Program. The original SCN Operations Manual v1 was released on August 9, 2024, and additional versions have been released since the original version 1. Revisions to the Manual may be required as OHIP seeks to provide additional details and clarification, or due to changes in guidance as a result of learnings from program implementation. Additional versions will be made available by OHIP as needed.

A summary of changes for each version is below.

- **ORIGINAL – Version 1 (August 9, 2024):** First release of OHIP's operational guidance for the SCN Program
- **Version 2 (October 29, 2024):** Includes additional details and clarifications to overall SCN guidance. Larger additions and revisions include (not exhaustive):
  - **SCN Infrastructure**
    - New guidance on HRSN service provider and ecosystem partner complaints
    - Clarifications on use of infrastructure funding for capacity building
    - Updates to SCN public website requirements
    - New section on public-facing materials related to SCN program
  - **Care Delivery Approach**
    - New guidance regarding identification of member major life events
    - New guidance on requirements for Social Care Navigation to be reimbursed using Waiver funds
    - Updates to Eligibility Assessment process (e.g., requirement to gather member consent, requirement to answer data fields for all questions)
    - Revised guidance on implications of changes in member Medicaid coverage
    - New section on determining member program eligibility through provider attestation and/or member documentation/attestation
    - Additional guidance and details for individual Enhanced HRSN Services added for services including Home Accessibility / Safety Modification, Home Remediation, Asthma Remediation, Medical Respite, Housing Transition and Navigation, and Transportation Services
  - **Performance**
    - Updated dates for major report submissions
    - New section on member complaints and reportable incidents to replace previous guidance
  - **Payments**
    - Clarified guidance on use of Infrastructure funding
    - Updated guidance for HRSN fee schedule and Enhanced HRSN Service rate types
  - **Contract Requirements**
    - New guidance regarding OHIP's SCN Conflict of Interest (COI) Plan requirement
    - Clarification on guidance for Health Homes contracting into the SCN

- **Data Governance, Privacy, and Security**
    - Updated dates for data and security deliverables

- **Version 3 (December 13, 2024):** Includes additional details and clarifications to SCN guidance. Larger additions and revisions include (not exhaustive):
    - **SCN Infrastructure**
        - Added additional detail on coding granularly and SCN IT platform functionality to enable Eligibility Assessment
    - **Care Delivery Approach**
        - Added member demographic questions to questions to be asked during Screening instead of Eligibility Assessment
        - Provided additional detail on how Social Care Navigators should conduct Eligibility Assessments, particularly sources of data for determining member Medicaid Managed Care (MMC) enrollment
        - Provided additional guidance on how Social Care Navigators should take into account households when navigating eligible members to Enhanced HRSN services
        - Added considerations for criminal justice-involved adults and justice-involved youth
        - Added specific timing for sharing of monthly Enhanced Services Member File (ESMF)
        - Updated Enhanced Population descriptions, clinical criteria, and Social Risk Factors per CMS
        - Provided additional detail on eligibility verification pathways, including suggested script for member attestation and details on provider attestation workflow
        - Clarified workflows for Home Remediation and Nutrition services
    - **Performance**
        - Adjusted guidance for Network Composition Report required components
        - Clarified guidance for handling of and reporting requirements for member complaints
    - **Payments**
        - Added additional guidance on reimbursement of services delivered by HRSN service providers within the SCN
    - **Data Governance, Privacy, and Security**
        - Clarified HITRUST certification requirements for SCN IT environments
        - Updated guidance for Summary of Privacy & Security requirements and deliverables

- **Version 4 (March 21, 2025):** Includes additional details and clarifications to SCN guidance. Larger additions and revisions include (not exhaustive):
    - **SCN Infrastructure**
        - Clarified eligibility for and intended use of community-based organization (CBO) capacity building funds
        - Provided additional detail on automated IT Platform logic expected to guide Social Care Navigators during Eligibility Assessment
    - **Care Delivery Approach**
        - Included additional considerations for youth and interpersonal safety (IPS) questions asked during Screening

        - Provided additional detail on how Social Care Navigators should perform Eligibility Assessments, including when to collect documentation for verification of Social Risk Factors
        - Clarified household guidance for Social Care Navigators, including how Social Care Navigators should approach select services that may scale for multiple members within the same household
        - Added guidance on youth residing in multiple households
        - Updated guidance for Social Care Navigators when members move across regions, including process to update member address
        - Provided additional detail on expected components of Social Care Plans, including technical requirement for platform vendors to generate a singular, comprehensive view of a member's Social Care Plan
        - Updated workflows for 2.1 Home Accessibility and Safety Modifications, 2.2 Home Remediation Service, and 2.3 Asthma Remediation (including service limitations and restrictions and allowable providers)
        - Clarified workflows for other Housing, Nutrition, and Transportation Services
        - Added additional guidance for Social Care Navigators on how to approach members that are already receiving potentially duplicative services
    - **Performance**
        - Provided additional detail on requirements for Infrastructure Cost Report and Quarterly Member Complaints Report
    - **Payments**
        - Clarified requirements for HRSN service providers to receive reimbursement
        - Clarified how HRSN service providers may braid funding sources to serve Medicaid members
        - Clarified how time spent on coordination should be billed for different services
    - **Contract Requirements**
        - Added additional detail around expectations for conflict of interest (COI) plans
        - Clarified how and when SCN Lead Entities can contract with Independent Practice Associations (IPAs) and Office of Mental Health (OMH) facilities
    - **Data Governance, Privacy and Security**
        - Added new Security and Privacy Section 10. OHIP Security and Privacy Requirements including the removal of HITRUST requirements
    - **Fee Schedule**
        - Added new Section 11. Fee Schedule with service-level detail from the HRSN fee schedule
- **Version 5 (August 1, 2025):** Includes additional details and clarifications to SCN guidance. Larger additions and revisions include (not exhaustive):
    - **SCN Infrastructure**
        - **Capacity funding:** Provided additional clarity on allowable uses of capacity building funding
        - **SCN websites:** Clarified expectations for SCN public websites (e.g., including Enhanced Population criteria)

        - **MEVS integration:** Added additional detail on expectations for SCN IT Platforms to integrate with MEVS
    - **Care Delivery Approach**
        - **Screening:** Clarified definition of a complete Screening and requirements for reimbursement
        - **Service re-authorization:** Specified guidance and processes for service re-authorization, including Navigator workflows and clarifications on the duration of eligibility for relevant services
        - **Potentially duplicative services:** Clarified guidance on potentially duplicative services (e.g., guidance for Social Care Navigators to coordinate with MCO case managers, guidance on Healthy Homes services)
        - **Enhanced HRSN services:** Provided additional detail on housing services, including clarifications on QA inspections, Dwelling Assessments, and bid solicitations
        - **Services for members in the same household:** Clarified expectations for providing services to members within households (e.g., criteria for a member to qualify for household-level nutrition support, household billing guidelines for utility services)
        - **Congestion pricing:** Added new guidelines for congestion pricing tolls incurred as part of private transportation services
        - **Foster care:** Added additional guidance on provision of HRSN services to children in foster care and transitioning out of foster care
        - **Member experience survey:** Clarified expectations for SCN-administered member experience survey
    - **Data Governance, Privacy, and Security**
        - **Quarterly POA&M and Quarterly Names List (QNL) Requirements:** Clarified activities for SCN Lead Entities to support oversight and compliance within Medicaid DUA and privacy/security protocols
    - **Fee Schedule**
        - **Harmonized guidance to align with Fee Schedule v4** (released on 6/16/2025) and **Fee Schedule v5** (released on 8/1/2025)
        - **Congestion pricing:** Added new modifiers related to congestion pricing
- **Version 6 (November 3, 2025):** Includes additional details and clarifications to SCN guidance. Larger additions and revisions include (not exhaustive):
    - **SCN Infrastructure**
        - **SCN IT Platform Requirements:** Added requirement that SCN IT platforms must retain all historical member data
        - **SCN Public Website:** Added best practices for self-screening tools
    - **Care Delivery Approach**
        - **Eligibility Assessment:** Added guidance on service duration pauses, expectations for Social Care Navigator outreach to members, definition of a "complete" EA, new guidance on what Social Care Navigators should do if unmet needs during EA differ from initial screening, guidance for additional household members for Nutrition services, and additional guidance for criminal justice-involved individuals
        - **SCN Referrals:** Clarified guidance on referral workflows

        - **Service Re-authorization:** Clarified that a new referral must be created for service re-authorizations
        - **Social Care Plan:** Added requirements for which care plan elements should be populated automatically or manually within SCN IT Platforms
        - **HRSN Services:** Clarified nature of 6-month service duration, which housing modification services are considered "invasive", updated guidance on bids required for home modifications, and added guidance on if member elects to change type of Nutrition service
        - **Attestation:** Added guidance that MCOs can provide written attestation in lieu of providers; clarified that provider attestations are valid for 1 year and only one method is required to validate member's eligibility
    - **Performance**
        - **Member Satisfaction:** Added additional guidance on requirements for member experience surveys administered by SCN Lead Entities and termination of member services
    - **Payments**
        - **PMPM Payments:** Added additional details on PMPM administration and reconciliation processes
    - **Contract Requirements**
        - **SCN Medicaid Billing Social Care Provider Designation and Enrollment:** Clarified that SCN Lead Entities are permitted to subcontract with vendors for select support
        - **SCN Contract Requirements with HRSN Service Providers and Other Entities:** Provided additional guidance on HRSN service providers, Certified Community Behavioral Health Clinics (CCBHCs) and Care Coordination Organizations (CCOs)
    - **Fee Schedule**
        - **Harmonized guidance to align with Fee Schedule v6** (released on 10/31/2025)
        - **Nutrition:** Clarified existing guidance; added household service codes and modifiers for Nutrition services
        - **Congestion pricing:** Removed U/U modifiers
- **Version 7 (January 31, 2026):** Includes additional details and clarifications on SCN guidance. Larger additions and revisions include (non-exhaustive):
    - **Care Delivery Approach**
        - **MLTCP/MAP members eligibility for nutrition and housing services:** Clarified that MLTCP/MAP members are eligible to receive 3.5 Cooking Supplies and that need for housing services can be addressed with member verbal attestation (vs. only through confirmation by MTLCP/MAP plan)
        - **ESMF services data:** For duplicative services, adjusted guidance to treat "U" (unknown) values in the ESMF similar to "N" (no) values if member verbally attests to not being enrolled in the program
        - **Eligibility Assessment:**
            - Clarified guidance that Navigators must check for service duplication, but can refer to other services (that don't require duplication checks) in the meantime
            - Clarified circumstances under which a re-screening may be billed upon discovery of changed screening answers during Eligibility Assessment

        - Created guidance that Navigators may contact a Health Home care manager for confirmation (verbal, digital, written) that member is enrolled in a Health Home
        - Clarified guidance on use of concurrent claim modifier when billing for same-day services to children living in multiple households
    - **Service duplication check workflow:** Clarified guidance that Navigators can outreach to other programs and MCO contacts for service duplication checks at the end of the EA and bill time under Enhanced Care Management
    - **Provider Attestation:** Added guidance to allow for electronic provider signatures (e.g., Docusign)
    - **Medicaid Redesign Team Housing:** Added Medicaid Redesign Team (MRT) housing providers to Partnerships section and clarified MRT provider reimbursement
    - **Clinical Criteria:** Clarified the clinical criteria for 2.4 Medical Respite and 3.2 Medically Tailored Meals
    - **Rent/Temporary Housing:** Clarified guidance that members should be placed in rental units that are financially sustainable for the member beyond the HRSN service duration
    - **Uncontrolled Asthma ESMF indicator:** Clarified that ESMF indicator for "Uncontrolled Asthma" meets clinical criteria to be eligible for a referral to 2.2 Asthma Remediation, 2.2a Home Remediation: Mold and Pest Remediation, and 2.2b Home Remediation: Ventilation Improving Systems without further documentation necessary
    - **Home Remediation referrals for members receiving Asthma Remediation services:** Clarified that members with Asthma Remediation referrals are eligible for 2.2a Home Remediation: Mold and Pest Remediation and 2.2b Home Remediation: Ventilation Improving Systems without provider attestation
    - **Billing for housing coordination:** Clarified billing guidance on member-facing and non-member facing time spent on coordinating housing services under 2.7 Pre-tenancy Services, 2.9 Tenancy Sustaining Services, 2.10 Housing Transition and Navigation Services, and Enhanced Care Management
    - **Transportation reimbursement:** Clarified guidance that Transportation Services are only reimbursable for actual services rendered to the member and are not reimbursable when a member fails to show up for an appointment
    - **Off platform screening:** Clarified off platform screening section to enhance existing guidance (corresponds to 1-pager on NYeC website)
- **Performance**
    - **Member Experience Survey:** Added the member experience survey to required quarterly reporting
    - **CBO Feedback:** Added guidance for SCN LEs to gather CBO feedback annually
    - **Operational Indicator Survey:** Clarified guidance on submission requirements and cadence for the operational indicator survey (replaces Monthly Horizon Report)
- **Payments**
    - **Same day services:** Clarified billing guidance for situations when a member receives a same service, same day, by same rendering provider

    - **Contract requirements:** Clarified that outpatient Article 16 OPWDD and Article 32 OASAS providers may contract with SCN LEs and receive reimbursement for Screening and Navigation
- **Data Governance, Privacy, and Security**
    - **SCN referral tracking:** Removed outdated guidance on SNOMED-CT referral codes
- **Fee Schedule**
    - **L1 Units:** Increased the maximum annual 1.1 Navigation Services units from 8 to 16 units
    - **Broker's fees:** Adjusted guidance that CTS Broker's Fees only apply to Long Island SCN region after the NYC passage of the FARE Act
    - **Asthma Self-Management Education:** Adjusted guidance to allow virtual video calls for the initial visit for 2.3a Asthma Self-Management Education (ASME)
    - **Housing Services:** Updated caps for 2.5 Rent / Temporary Housing and 2.8a Community Transitional Supports (CTS) to 2026 HUD Fair Market Rents

Version 8 (May 1, 2026): Includes additional details and clarifications on SCN guidance. Larger additions and revisions include (non-exhaustive):

- **Care Delivery Approach**
    - **Verbal and email attestations:** Provided flexibility for MCOs and Health Homes to attest to a member's eligibility for Enhanced HRSN Services using verbal attestation, HIPAA compliant email confirmation, care coordination notes in the SCN IT Platform, or Provider Attestion form. Allowed flexibility for other providers to attest to a member's eligibility criteria through HIPAA compliant email confirmation or Provider Attestation form
    - **Eligibility for Enhanced HRSN Services:** Updated eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service (Table 5-15)
    - **Additional non-invasive services:** Expanded non-invasive measures list to include non-invasive deep cleaning prior to 2.1 Home Accessibility and Safety Modifications, 2.2a Mold and Pest Remediation, 2.2b Ventilation Improving Systems, or 2.3 Asthma Remediation
    - **Non-invasive measures provided by ASME providers:** Clarified that ASME providers may provide non-invasive Asthma Remediation services if needed prior to SOW
    - **MRT and ESSHI provider guidance:** Updated guidance to include expectations that SCNs will initiate contracting with Medicaid Redesign Team (MRT) Supportive Housing subcontractors and Empire State Support Housing Initiative (ESSHI) providers
    - **Enhanced Population status on ESMF:** Clarified that Navigators do not need to ask the member for further support to verify their "yes" enhanced population or clinical criteria status as noted in the ESMF
    - **Health Care Provider capacity funding:** Added guidance on capacity building funds for Health Care and Behavioral Health Care Providers to hire Social Care Navigators to screen, assess, and refer members to HRSN Services
    - **Social Care navigation billing:** Clarified that Social Care Navigation is inclusive of member-facing and non-member-facing coordination

- **Members experiencing interpersonal violence:** Clarified that members experiencing interpersonal violence should be prioritized and navigated to services as close to same day of the eligibility assessment as possible
- **Temporary hotel stays for members with IPV:** Expanded hotel/motel stay coverage to members experiencing interpersonal violence so long as the Social Care Navigator, housing provider, and member are developing a permanent, long-term housing, or transitional housing plan in parallel
- **"Completing" referrals for SNOMED code clarity:** Added guidance that L1 and L2 services should be marked as "completed" by Navigators to ensure data is accurate when pulling SNOMED codes

- **Performance**
  - **Infrastructure Cost Report:** Updated reporting cadence to reflect new monthly reporting requirement
  - **Infrastructure funding:** Updated percentage of infrastructure funds tied to required reporting and performance in PY 2 Q4
    - Updated required reporting percentages from 85% to 80%
    - Updated performance percentage from 10% to 15%

- **Payments**
  - **HRSN Service Provider invoicing:** Added guidance that HRSN Service Providers must submit invoices no later than 5 business days after the service delivery date
  - **SCN claim submission:** Shifted requirement for SCNs to submit all claims to MCOs no later than 10 business days from payment date
- **Data Governance, Privacy, and Security**
  - N/A
- **Fee Schedule**
  - **Alignment with April 1, 2026 Release:**
    - Made updates to program-level caps (e.g., CTS Brokers Fee, Cooking Supplies and Transportation) to align with the HRSN Fee Schedule Version 8 released on April 1, 2026
    - Removes coverage of broker's fees from Manhattan, Bronx, Brooklyn, Queens, Staten Island in response to legislative changes in New York City and maintains coverage for Long Island

1. GLOSSARY OF COMMON TERMS

Term	Definition and term details
Accountable Health Communities (AHC) Health-Related Social Need (HRSN) Screening Tool	Standard New York Health Equity Reform (NYHER) HRSN assessment instrument used to assess unmet HRSN needs
Community based organization (CBO)	501(c)(3) or 501(c)(4) non-profit community focused organization that provides HRSN services directly to members CBOs may or may not bill Medicaid within their organization. CBOs may contract with Social Care Network (SCN) Lead Entities to become part of a SCN. (*See Roles and responsibilities of entities within the Social Care Network and broader ecosystem for more information*)
Clinical Criteria	The set of clinical criteria which renders a Medicaid Managed Care member eligible for a specific Enhanced HRSN Service (e.g., Asthma Remediation) Member must demonstrate medical necessity for individual Enhanced Services and criteria is located within the Enhanced Services Member File (*See Clinical Criteria for more information*)
Data and Systems Implementation Guide (DSIG)	An implementation guide ~~document~~ developed by OHIP to provide member enrollment and population identification, HRSN billing, claims, and data management guidance for the successful implementation of the NYHER Program Note: There are 2 versions of the DSIG tailored to SCN Lead Entity and MCO audiences
Detailed Business Requirements (DBRs)	Comprehensive definitions of metrics contained in performance management reports, including, specific inputs and calculations required to measure those outcomes (e.g., numerators, denominators)
Ecosystem partners	Entities not contracted into the SCN but that may collaborate with the SCN, including but not limited to managed care organizations (MCOs), local agencies / departments, and health care providers, inclusive of behavioral health and primary care providers, that may work with SCN but are not formally part of the Network (*See Roles and responsibilities of entities within the Social Care Network and broader ecosystem for more information*)

Term	Definition and term details
Eligibility Assessment	Assessment of a member's eligibility for NYHER-financed Enhanced HRSN Services conducted by a Social Care Navigator. Eligibility is based on criteria defined by the Office of Health Insurance Programs (OHIP). This assessment takes place after Screening and before service delivery in the NYHER process (*See Eligibility Assessment for more information*)
Enhanced Health-Related Social Need (HRSN) Services	Services reimbursed by OHIP for eligible Medicaid Managed Care members Services include Care Management, Housing, Nutrition, and Transportation
Enhanced Services Member File (ESMF)	The Enhanced Services Member File indicates a Medicaid Managed Care member's potential eligibility for Enhanced HRSN Services based on clinical criteria listed within this document in addition to member information obtained during the Eligibility Assessment. Social Care Navigators must collectively use this information to determine which Enhanced HRSN Services a member is eligible for during the Eligibility Assessment. The file pathway for the Enhanced Services Member File is from the MCO to New York eHealth Collaborative (NYeC)/ Statewide Health Information Network for New York (SHIN-NY) then QEs and finally to the SCNs. The Enhanced Services Member File will be sent on a monthly basis
ePACES	Electronic Provider Assisted Claim Entry System (ePACES), a web-based application which will allow providers to create / submit claims and other transactions (e.g., Eligibility check and Prior Approval) in Health Insurance Portability and Accountability Act (HIPAA) format. ePACES is a component of the eMedNY system, which was developed on behalf of the New York State (NYS) Department of Health. To contact eMedNY please email: eMedNYHIPAASupport@gdit.com or call: 1-800-343-9000
Health care provider	Entities providing health care to individuals, including Medicaid members. Health care providers include providers of behavioral health, primary care, and other licensed practitioners
Homeless	***Homeless*** As defined by U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, 4 categories of homelessness: • Literally homeless • Imminent risk of homelessness • Homelessness under other federal regulations • Fleeing / attempting to flee domestic violence ***At-risk of homelessness*** As defined by U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, 3 categories of at-risk of homelessness for: • Individuals and families

Term	Definition and term details
	• Unaccompanied children and youth • Families with children and youth (*See Social Risk Factors, Clinical Criteria, or Covered HRSN Services for more information)*
Health-Related Social Need (HRSN) Services	Any health-related social needs services that are NYHER-financed as approved by the Federal Government The scope of HRSN services is broader than NYHER-financed services that are included as part of the SCN program. For simplicity, HRSN Services in this Manual refers exclusively to services that are NYHER-financed as approved by the Federal Government
HL7 FHIR	Fast Health Interoperability Resources (FHIR) is a standard for health care data exchange, published by Health Level Seven International (HL7), a not-for-profit, accredited standards development organization
HRSN service provider (also "the Network" or "organizations in the Network")	Entities contracted into the SCN that conduct NYHER activities and deliver HRSN services (including but not limited to CBOs, health care providers, for-profit organizations, etc.) (*See Roles and responsibilities of entities within the Social Care Network and broader ecosystem for more information*)
ICD-10-CM	The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a standardized system used to code diseases and medical conditions (morbidity) data. Health care providers use ICD-10-CM codes when diagnosing patients. ICD-10-CM builds on ICD-10 (the International Classification of Diseases, Tenth Revision)— the system used to code causes of death on death certificates. Please see Social Care Coding document for SCN IT Platform requirements
LOINC	Logical Observation Identifiers Names and Codes (LOINC) is clinical terminology that provide a definitive data standard for identifying clinical information in electronic systems. LOINC is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information. One of the main goals of LOINC is to facilitate the exchange and pooling of results for clinical care, outcomes management, and research. Please see Social Care Coding document for SCN IT Platform requirements
Major life event	Permanent or fluctuating event in a member's life that makes a member eligible for reimbursed HRSN Re-screening

Term	Definition and term details
	A major life event may be identified by any contracted entity within the SCN that is authorized to have direct contact with a member (e.g., through Screening, Eligibility Assessment, HRSN service delivery, service follow-up) Major life events may include: • Change in functioning (including an increase or decrease of symptoms or a new diagnosis); • Inpatient or outpatient hospital admittance and/or discharge; • Serious injury; • Admittance, discharge, or transfer from detox or residential placement; • Significant change in housing, including move to a different SCN region, move to different housing, or loss of housing; • Significant change in income or support resources; • Significant change to family, including but not limited to: marriage or divorce; giving birth (regardless of outcome) to or adopting a child, loss of a family member; • Arrest; • Loss of benefits; • Change in coverage from FFS to Managed Care
Medicaid billing social care provider	OHIP designation for SCN Lead Entities Becoming designated as a Medicaid billing social care provider will enable SCN Lead Entities to contract with MCOs to facilitate payment for the provision of Screening, Navigation, and Enhanced HRSN Services for Medicaid Managed Care members. Additionally, SCN Lead Entities will be able to bill via eMedNY directly for HRSN Screening and Navigation of Medicaid Fee-For-Service (FFS) members (*See SCN Medicaid Billing Social Care Provider Designation and Enrollment for more information*)
Medicaid Eligibility File (MEF)	The Medicaid Eligibility File denotes Medicaid eligibility for FFS and Medicaid Managed Care members as of the date it was pulled. The file is sent to SCNs via the following pathway: OHIP/MDW to NYeC, then to QEs, and finally to the SCNs. The Medicaid Eligibility File is sent on a weekly basis, and thus a member's enrollment may be outdated at point of contact with the SCN or their Network. ePACES or MEVS Medicaid eligibility data is the most current source of Medicaid eligibility status
Medicaid Eligibility Verification System (MEVS)	MEVS is a component of the eMedNY system operated by New York State that enables providers and other authorized entities to verify member eligibility and enrollment details in real-time prior to providing services and to obtain authorization for specific services. MEVS is required to be integrated within the

Term	Definition and term details
	SCN IT Platform as a permanent technical infrastructure of the SCN IT Platform for the ability to query and verify a member's Medicaid eligibility at the time of service. To contact eMedNY please email: eMedNYHIPAASupport@gdit.com or call: 1-800-343-9000
Medicaid Fee-For-Service (FFS)	Medicaid Fee-For-Service (FFS) is a payment model in which OHIP pays for services for Medicaid beneficiaries, directly paying participating physicians, clinics, hospitals, and other providers a fee for each service they furnish. FFS members whose HRSN Screens demonstrate unmet HRSNs and who are interested in receiving support for those needs should receive an HRSN Eligibility Assessment. For the SCN Program, the Medicaid FFS population will only be eligible for Navigation to existing local, state, and federal services
Medicaid Managed Care (MMC)	Medicaid Managed Care is a health care delivery system organized to manage cost, utilization, and quality inclusive of mainstream, HIV-SNPs, HARP, and MLTCP / MAP. Medicaid Managed Care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between OHIP and Managed Care Organizations (MCOs) that accept a set per member per month (PMPM capitation) payment for these services MMC members whose HRSN Screens demonstrate unmet HRSNs and who are interested in receiving support for those needs should receive an HRSN Eligibility Assessment. For the SCN Program, Enhanced HRSN Services will be provided to MMC members who meet certain criteria
OHIP	New York State Office of Health Insurance Program, the entity that oversees the SCN program
NYHER Population	MMC and Medicaid FFS populations that may receive Screening, Navigation, and Enhanced HRSN Services (eligible MMC only) as part of SCN program
Population Eligible for Enhanced HRSN Services	Medicaid Managed Care members who meet specific criteria related to Social Risk Factors, Enhanced Population Alignment, and Clinical Criteria (*For additional details, see Introduction to member eligibility and medical appropriateness for more information*)
Qualified Entity (QE)	Regional health information networks that store and share patient health information The QEs allow participating health care professionals, with patient consent, to quickly access electronic health information and securely exchange data statewide *(For additional information on QE / SCN Lead Entity contract responsibilities, see SCN Contract Requirements. If an SCN Lead Entity is not yet connected with a QE, visit How to Connect & Use the SHIN-NY)*

Term	Definition and term details
Referral	Referrals to Enhanced HRSN Services will be a core element of the SCN program, wherein Social Care Navigators connect eligible members to HRSN service providers. Referrals will be "Closed Loop", meaning that when a member is referred for Enhanced HRSN Services, the Social Care Navigator will coordinate the member's connection to available resources and follow up to ensure services were rendered. Please see Social Care Coding document for SCN IT Platform requirements
SCN Lead Entity	Entity responsible for coordinating the Network of HRSN service providers and health care providers The SCN Lead Entity contracts with OHIP, MCOs, and organizations within the Network (*See Core responsibilities of SCN Lead Entities for more information)*
Screening	Process of identifying the unmet HRSNs of Medicaid members OHIP's aim is that every Medicaid member receives an HRSN Screening annually and on an as-needed basis. Members will be screened using a standardized New York version of the AHC Screening Tool to assess member HRSNs related to housing and utilities, nutrition, transportation, employment, education, and interpersonal safety (*See Screening for more information)*
SHIN-NY (Statewide Health Information Network for New York)	Facilitates the secure electronic exchange of patient health information and connects health care professionals statewide In partnership with New York State, New York eHealth Collaborative (NYeC) developed and manages the technology platform that connects New York's QEs and enables the sharing of data statewide, ensuring that the SHIN-NY provides access to a patient's electronic medical records. By utilizing the SHIN-NY, health care professionals make informed decisions faster, enabling collaboration and coordination of care to improve patient outcomes, reduce unnecessary and avoidable tests and procedures, and lower costs (*For more information on 1115 SHIN-NY Interoperability Guidance for SCN Lead Entities and their IT Platform partners, visit the NYeC Website 1115 Waiver support website*)
SNOMED-CT	Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of comprehensive health information. The clinical terminology is owned and maintained by the coding steward, SNOMED

Term	Definition and term details
	International, a not-for-profit association. Please see Social Care Coding document for SCN IT Platform requirements
Social Care Coding	Social Care Coding outlines the required SCN IT Platform functionality for Screening (LOINC question and answer pairs), and mapping from Screening response to Eligibility Assessment coding (required ICD-10 and SNOMED codes/descriptions) that must be utilized by Social Care Navigators. Social Care Coding also includes coding requirements for mapping HRSN Services (SNOMED codes) to billing (HCPCS codes/descriptions, Procedure Codes, and Modifiers). Lastly, Social Care Coding is utilized for SNOMED Goal Codes applicable for Year 3. Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the most current Social Care Coding document or via NYeC's NYHER 1115 Extranet
Social Care Navigation (also called Navigation)	Process by which member facing and non-member facing coordination efforts are provided to eligible MMC members ~~are referred~~to support referral to the appropriate Enhanced HRSN service providers. Process is inclusive of providing FFS and MMC members ~~are navigated~~ navigation to existing federal, state, or local resources *(See Social Care Navigation for more information)*
Social Care Navigator (also called Navigator)	Conducts member facing and non-member facing coordination efforts and refers eligible MMC members to the appropriate Enhanced HRSN service providers. Responsibility is inclusive of ~~and~~ connecting and navigating~~s~~ FFS and MMC members to existing federal, state, or local resources *(See Social Care Navigation - linked above - for more information)*
Social Care Plan	Documentation of care considerations for delivery of HRSN services to eligible Medicaid Managed Care members Social Care Plans are developed by Social Care Navigators and intended to be longitudinal and revisited as services are rendered and needs are met. Social Care Plans are developed for members that belong to Enhanced Services Population(s)
Social Risk Factors	After being determined to be a part of an Enhanced Population, members are assessed by their Social Care Navigator for Social Risk Factors. For each response from the member's Screening results that identifies an unmet HRSN, the Social Care Navigator must assess the related Social Risk Factor (*See Social Risk Factors for more information*)

2. ABOUT THIS OPERATIONS MANUAL

Purpose of this manual: The purpose of this manual is to provide program, billing, and data governance guidance to SCN Lead Entities designated by OHIP.

This includes requirements governing the delivery of HRSNs services to New York's Medicaid FFS and Medicaid Managed Care members, as well as instructions related to data management, data security and data sharing; and instructions for submitting reporting to support the integration of social, physical, and behavioral health care within Medicaid.

This manual is a living document: *This Operations Manual is a living document and will be updated frequently.* For questions regarding content in the SCN Operations Manual, reach out to: sdh@health.ny.gov

SCN Lead Entities may also direct questions to their OHIP contract manager.

Intended audiences: While SCN Lead Entities are the primary audience for this manual, it contains information that is also relevant for several other audiences, including CBOs and other HRSN service providers, MCOs, and health care providers (inclusive of behavioral health and primary care providers).

3. INTRODUCTION

Introduction sub-sections:

a. Vision and Goals for SCN Program

b. Overview of SCN Program Design

c. Overview of SCN Regions

d. Overview of HRSN Services

e. Overview of Entities in the Social Care Ecosystem

a. VISION AND GOALS FOR SCN PROGRAM

i. Background

The mission of New York State is to protect and promote health for all, building on a foundation of health equity. In New York and nationally, there is growing recognition that fully achieving health for all requires a focus not only on physical and behavioral health, but also on HRSNs.

It is now widely acknowledged that addressing social needs such as food insecurity, housing instability, and lack of transportation improves health and lowers health care costs. To ensure that these needs are consistently addressed for New York's Medicaid members, our state needs a coordinated infrastructure and set of processes through which people's unmet HRSNs can be identified, people can be connected to services to address those needs, and the organizations who provide those services can be paid.

ii. What are Social Care Networks?

To meet that need, OHIP has established regional SCNs across the state to ensure that the HRSNs of Medicaid members are more consistently identified and addressed.

Each SCN is comprised of a Lead Entity who contracts and coordinates with a network of CBOs and other organizations providing HRSN services as well as other providers (inclusive of behavioral health and primary care providers). Together, each Network will be responsible for ensuring that this is a seamless, consistent end-to-end process in their region for HRSN Screening, Navigation, and delivery of HRSN services. This will require close collaboration within each Network, as well as shared data and technology. All entities contracted into the SCN for Screening, Navigation, and/or service delivery are collectively referred to as HRSN service providers throughout this Manual.

Each region's SCN Lead Entity will be responsible for driving this work in their region, including building, supporting, and overseeing the Social Care Network.

iii. Goals for SCN program

OHIP's vision is that the creation of SCNs will achieve four goals for Medicaid members:

- Enable consistent, timely Screening using the NYS standardized version of the Accountable Health Communities (AHC) HRSN Screening Tool and Navigation to HRSN services
- Create shared end-to-end visibility of the member journey from HRSN Screening and Navigation through delivery of HRSN services
- Expand access to high-quality HRSN services
- Strengthen collaboration between HRSN service providers and other partners in their regional health ecosystem, including, providers, care managers, and health plans

OHIP is committed to a SCN program that not only improves health outcomes for Medicaid members but also does so in a way that advances health equity by helping to address long-standing health disparities and supporting and strengthening existing work already being done by CBOs.

b. OVERVIEW OF SCN PROGRAM DESIGN

i. Responsibilities of SCN Lead Entities

SCN Lead Entities are regional organizations charged with building strong Social Care Networks of contracted organizations to collectively ensure consistent Screening, Navigation, and delivery of HRSN Services for the Medicaid members in their area.

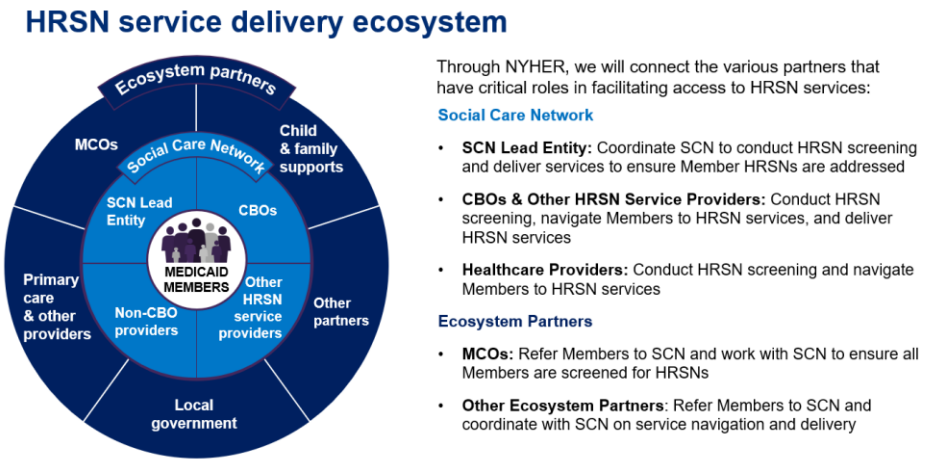
The core responsibilities of SCN Lead Entities include:

- Build and maintain a comprehensive Social Care Network of contracted organizations that collectively screen all Medicaid members in their region for HRSNs, navigate members with HRSNs to appropriate services, provide high-quality HRSN services, and provide data and reporting on these activities
- Enroll in the New York State Medicaid Program as a Medicaid billing social care provider. SCN Lead Entities will be Medicaid billing social care providers. They will be re-designated by NYS every five years and must also revalidate with the Medicaid program every five years. (*See SCN Medicaid Billing Social Care Provider Designation and Enrollment for more information*)
- Ensure more intensive coordination of HRSN services for Medicaid Managed Care members eligible for Enhanced HRSN Services. This includes individuals who are Medicaid High Utilizers, individuals enrolled in a NYS Health Home, pregnant and postpartum persons, criminal justice-involved populations with chronic or mental health conditions, high risk children under the age of 18, and people living with Intellectual and/or Developmental Disabilities, Serious Mental Illness, or Substance Use Disorders (*For additional guidance on eligible members, see Medicaid Member Eligibility*)
- Create a more accessible customer experience for Medicaid members seeking HRSN services through Social Care Navigation and Closed Loop Referrals
- Build the capacity of CBOs to provide high-quality HRSN services and to manage new or increased administrative responsibilities through capability-building and reliable funding streams
- Establish financially and operationally sustainable, self-innovating ecosystems that will continue to deliver services after the end of the NYHER 1115 Waiver amendment period
- Promote more equitable delivery of HRSN services and address the health, racial, ethnic, socioeconomic, and geographic disparities in existing access and quality

To achieve the above goals, OHIP will support SCN Lead Entities to become responsible for the coordination of HRSN service delivery in each region (*see Figure 3-1*).

SCN Lead Entities will maintain and strengthen a comprehensive SCN of HRSN service providers responsible for delivering evidence-based and member-centric HRSN services. This Network will also capture and share data required for effective coordination between the SCN Lead Entities, HRSN service providers, OHIP, and other stakeholders, to help evaluate the SCNs' impact on health outcomes.

Figure 3-1: Overview of SCNs in context of broader health care and social care ecosystem



ii. Statewide SCN data and technology infrastructure

A critical component of the SCN infrastructure will be the creation of a statewide, multi-sector data and technology infrastructure for HRSNs. This will require secure and actionable data exchange enabling delivery of needed services to Medicaid members at the right place and right time, and data collection to enable the evaluation of the SCN program's impact on members' health outcomes and health care costs.

iii. HRSN fee schedules

To ensure the financial sustainability of the delivery of these HRSN services, OHIP approved regional HRSN Fee Schedules submitted by each SCN Lead Entity, with services approved by the Centers for Medicare & Medicaid Services (CMS), to reimburse HRSN service providers for HRSN services provided to eligible Medicaid members. The HRSN fee schedule includes guidance on service delivery requirements for services to be reimbursed, maximum allowable units, maximum duration, billing codes / modifiers, and rates / ranges / caps for each service. (*For additional information, see Payment Methodology for Services Delivered*).

c. OVERVIEW OF SCN REGIONS

OHIP has awarded 9 SCN Lead Entities for a contract term running from August 1, 2024 – March 31, 2027. The following nine organizations were selected and will be covering thirteen regions throughout the State.

Table 3-1: SCN Lead Entities by region

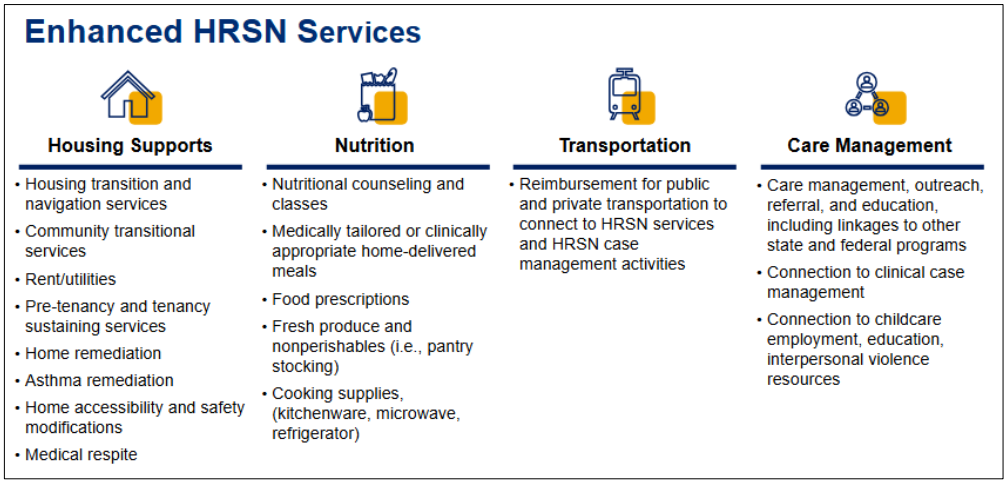
Organization	Region
Care Compass Collaborative	Southern Tier
Forward Leading IPA Inc.	Finger Lakes
Health Equity Alliance of Long Island	Long Island
Healthy Alliance Foundation Inc.	Capital Region, Central NY, North Country
Hudson Valley Care Coalition, Inc.	Hudson Valley
Public Health Solutions	Manhattan, Queens, Brooklyn
Staten Island Performing Provider System	Staten Island, select zip codes in Kings (Brooklyn) and Queens in partnership with Public Health Solutions
Somos Healthcare Providers, Inc.	Bronx
Western New York Integrated Care Collaborative Inc.	Western NY

d. OVERVIEW OF HRSN SERVICES

OHIP has worked with CMS to establish criteria to determine which Medicaid members will be eligible to receive specific, evidence-based HRSN services (e.g., Housing supports, Nutrition, Transportation, Care Management) reimbursed using Medicaid dollars. These reimbursed HRSN services are referred to as Enhanced HRSN Services (*see Figure 3-2*).

Medicaid members who have identified HRSNs but do not meet specific eligibility criteria will be navigated to HRSN services delivered by existing state, federal, and local programs. Services provided by existing state, federal and local programs for these members will not be eligible for Medicaid reimbursement as part of the SCN program.

Figure 3-2: Social Care Network Enhanced HRSN Services



e. OVERVIEW OF ENTITIES IN THE SOCIAL CARE ECOSYSTEM

SCN Lead Entities will work closely with their Networks to identify and address HRSNs among Medicaid members in each region. They will also work with a broader set of partners (e.g., MCOs, providers, health systems, child welfare service agencies, jails, local Departments of Social Services) to help address the needs of members.

i. Roles and responsibilities of entities within the SCN and broader ecosystem

- *SCN Lead Entities:* The OHIP-designated Lead Entity is responsible for:
    - **Network development***:* Organizing a Network of Screeners and HRSN service providers that will deliver HRSN Screening and HRSN services to eligible Medicaid Managed Care members. SCN Lead Entities will ensure the network has sufficient capacity to meet demand for Screening and HRSN services
    - **Screening and Navigation:** Collaborating with partners in regional ecosystem (e.g., CBOs, MCOs, providers, etc.), screen members for HRSNs, validate member eligibility for Enhanced HRSN Services and navigate to the appropriate services, manage and close the loop on referrals, and deliver Enhanced HRSN Services through contracted HRSN service providers in the Network
    - **Network capacity building:** Building ongoing capacity of Screeners, Social Care Navigators and HRSN service providers in the Network to meet demand for HRSN Screening and service delivery, via direct investments (e.g., support staff hiring, onboarding onto IT Platform, purchasing of necessary equipment such as computers), or through trainings and technical assistance

- **Fiscal management:** Contracting with MCOs to facilitate payments for HRSN services delivered by HRSN service providers, by becoming a designated Medicaid billing social care provider and submitting social care claims to MCOs
- **Shared data and technology infrastructure:** Establishing regional digital connectivity between the SCN, OHIP, and other stakeholders, and empowering organizations that work directly with members by providing necessary data through an accessible IT platform. This platform will support HRSN Screening and Navigation, data sharing and reporting, reimbursement of HRSN service providers, and claims submission. This role includes maintaining a clear set of business processes for data and technology activities and adopting interoperable standards for a social care data exchange, including integration with clinical data through the Statewide Health Information Network for New York (SHIN-NY)
- **Data governance:** Establishing data governance processes and procedures to manage both how data flows internally within the SCN and how data flows externally as it is exchanged between the SCN and other stakeholders outside the SCN, such as the MCO, OHIP, and external evaluators. Data governance includes ensuring that data is consistent, complete, interoperable, secure, discoverable, and trustworthy
- **Performance management:** Collaborating with HRSN service providers and MCOs on data-driven performance reporting to demonstrate value and continue to strengthen the evidence base on HRSN services' impact in improving health outcomes, reducing health disparities, and reducing health care costs
- **Operations and governance:** Establishing and maintaining a governing body and executive leadership team that reflects and understands the unique needs of the region and effectively coordinates among other stakeholders in the region

- *Community based organizations:* CBOs are primarily responsible for delivering HRSN services. CBOs may also conduct HRSN Screening and Navigation to services for Medicaid members, if designated to do so by the SCN Lead Entity upon meeting specific criteria
- *For-Profit Organizations:* OHIP's intent is that SCNs will be composed primarily of not-for-profit entities providing Enhanced HRSN Services. However, OHIP recognizes that there may occasionally be circumstances where inclusion of a for-profit entity may be necessary to ensure timely and consistent access to Enhanced HRSN Services. SCNs will need to communicate inclusion of for-profit entities in the SCN's Network Composition Plan and Report. OHIP approval is not required for inclusion of for-profit entities in the Network. OHIP reserves the right to request additional information or clarification on inclusion of a for-profit entity and to request they be excluded from the Network in the event that non-profit alternatives are able to deliver Enhanced HRSN Services. If a for-profit entity is contracted into a SCN and delivers Enhanced HRSN Services but is later determined to be excluded from the SCN, they will still be reimbursed for services they have already delivered

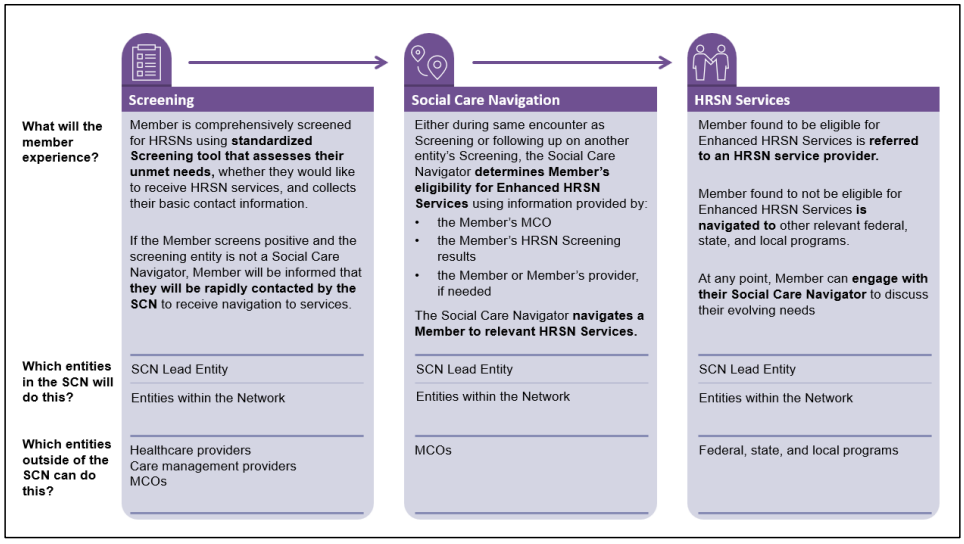
  (*See HRSN Network Capacity and Access*)
- *Medicaid Managed Care Organizations:* MCOs are expected to contract with SCNs and will be responsible for the distribution of per-member-per-month (PMPM) payments to SCN Lead Entities. Funding will be provided to MCOs by OHIP for the purpose of making PMPM payments for Medicaid Managed Care members. MCOs will also be responsible for providing information to SCNs to help validate member eligibility for Enhanced HRSN Services delivered by the SCN

MCOs with access to the SCN Lead Entity's IT Platform may also provide Screening and Navigation, if designated to do so by the SCN Lead Entity. MCOs are responsible for updating their educational materials (e.g., Member Handbook, Member Notice, MCO Presentation) to inform members about SCN services. Educational materials must be approved by OHIP prior to release

- *Health systems and other health care providers:* Health system partners and other health care providers, inclusive of hospitals and other physical health and behavioral health providers, will continue to deliver health care services to Medicaid members in their region. Health care providers that are already conducting HRSN Screening are encouraged to continue to do so. They may choose to become part of the SCN (allowing them to be reimbursed for Screening)
- *Other Ecosystem Partners:* Other ecosystem partners (including but not limited to local Departments of Social Services, jails, 29-I agencies, child welfare and preventative service providers, etc.), will be important partners to Networks. Ecosystem partners may refer members to the SCN for Screening and/or conduct Screening themselves

OHIP envisions these entities working together to ensure that the member experience from Screening to service completion is seamless and that members can access services appropriate for their needs in a timely fashion.

Figure 3-3: Member experience across Screening, Eligibility Assessment, Navigation, and receipt of HRSN services



4. SCN INFRASTRUCTURE

SCN Infrastructure sub-sections:

a. HRSN Network Capacity and Access

b. Governance Requirements

c. SCN IT Platform Requirements

d. Training Expectations

e. SCN Public Website

f. Public Materials on SCN Program

a. HRSN NETWORK CAPACITY AND ACCESS

i. Overview

The importance of strong HRSN Networks: For any service that Medicaid covers, OHIP knows that the service cannot just be available in theory but should be easy, convenient, and equitable to access when and where people need it.

For health care services, state Medicaid programs often require Medicaid Managed Care Organizations to meet both network adequacy standards (e.g., requiring that all Medicaid members live within a defined distance in miles or by minutes of car traveling time of a primary care provider in their health plan's network) and network capacity guidelines (e.g., requiring that certain functions are available during set hours and days, and that routine activities are completed in a timely and culturally / linguistically appropriate way).

While some of the details of how network capacity and access are monitored are somewhat different for HRSN services than for health care services, the vision is the same: consistent, convenient access to services that meets people where they are in an equitable, customer-centered way.

Strong, accessible Networks are critical to ensure that SCNs effectively address members' HRSNs and improve their health outcomes. This includes ensuring that as much of the Medicaid population as possible is screened for unmet HRSNs, that members with identified HRSNs are quickly and consistently connected to services, and that those services are available in members' communities from a diverse and culturally competent network of HRSN service providers.

OHIP's approach to HRSN Network capacity and access: To ensure strong HRSN Networks in the SCN program, OHIP has established criteria for HRSN network capacity and access and will systemically monitor a set of HRSN network capacity and access measurements to inform initial network composition and drive continuous network improvement over time.

SCN Lead Entities are responsible for designing and maintaining a Network of organizations that can serve members in each region. This entails screening all Medicaid members for HRSNs using the AHC HRSN Screening Tool, validating member eligibility for Enhanced HRSN Services, and referring those members to organizations in the Network who will deliver the appropriate services.

Table 4-1 summarizes the network capacity and adequacy guidelines that SCN Lead Entities are held to by OHIP. In some cases, these standards are *requirements* for SCN Lead Entities. In other cases, these standards are *guidance* that is encouraged and will be monitored but are not required. SCN Lead Entities are accountable for ensuring that these guidelines are met, which will require close collaboration between HRSN service providers and other organizations in the Network.

OHIP understands that building HRSN Networks will be a new responsibility for many SCN Lead Entities, and that achieving comprehensive and inclusive networks is an ongoing process. Inability to meet requirements will not result in withholding of funds or resources while Networks are being established. OHIP plans to support SCNs to achieve HRSN capacity and access through both capacity building funds and direct technical assistance.

HRSN capacity and access expectations may be revised over time as new program data is available.

Prioritizing diverse, inclusive, and culturally component networks: OHIP intends for SCNs to include organizations who represent the diverse populations and communities that the SCN program will serve. This includes the many HRSN service providers and other entities who already play a critical role in addressing the HRSNs of Medicaid members today.

Towards that goal, SCNs should be composed primarily of non-profit organizations (per Federal Employer Identification Number (EIN) from the IRS) of a variety of sizes and types, and in particular should include organizations with annual budgets of less than $5 million. Each SCN should also be able to provide Screening, Navigation, and Enhanced HRSN Service Delivery in the languages preferred by Medicaid populations in their region. Social Care Networks should include not only a wide variety of HRSN service providers, but also all interested health care providers, inclusive of behavioral health and primary care providers, and potentially other entities such as local Departments of Social Services, local health departments, school districts, and others.

More information on the types of organizations, linguistic competencies, and inclusivity expectations for SCNs is provided later in this section.

ii. HRSN capacity and access guidelines and requirements

SCNs are expected to achieve at least adequate HRSN network capacity and access across many functions. For each area, OHIP has provided guidance and reporting expectations, and in some cases set requirements (*see Table 4-1*).

Table 4-1: Guidelines and Requirements for Social Care Network composition to ensure HRSN capacity and access

Adequacy Dimension	Guidance for SCNs *(monitored – see Performance Management)*	Requirements for SCNs *(reported via routine reporting, see Reporting section for details)*
SCN Function: Screening and Eligibility		

Adequacy Dimension	Guidance for SCNs *(monitored – see Performance Management)*	Requirements for SCNs *(reported via routine reporting, see Reporting section for details)*
Screening capacity	*See requirement*	• **75%** of Medicaid population screened between service start and March 31, 2026. Consistent with guidance that OHIP has previously shared, OHIP expects that SCNs are aspiring to screen 75% of Medicaid members by March 31, 2026, as a stepping-stone to the broader program aspiration of screening all Medicaid members. At a minimum, SCNs must screen 25% of members by March 31, 2026. OHIP expects that most SCNs will significantly exceed the 25% minimum by 3/31/26 • **100%** of Medicaid population screened between April 1, 2026 – March 31, 2027
Eligibility and Navigation capacity	*See requirement*	• Required minimum **85%** of members with an identified unmet HRSN[2] are successfully contacted[1] within **5 business days** • Required minimum **85%** of eligible members with an identified unmet HRSN[2] are navigated to existing federal, state, and local programs **within 7 business days** **(Reported via ICD 10/SNOMED codes and "Completed" status)** • Required minimum **85%** of eligible members with an identified unmet HRSN[2] are referred to Enhanced HRSN Services **within 7 business days** **(Reported via ICD 10/SNOMED codes and "Completed status")**
Screener population competencies	Screeners should have relevant cultural / linguistic competency based on needs of members in region	*See guidance; no requirement*
Distance / access to members	Screeners should be able to reach all members via either an in-person or virtual Screen	*See guidance; no requirement*

Adequacy Dimension	Guidance for SCNs *(monitored – see Performance Management)*	Requirements for SCNs *(reported via routine reporting, see Reporting section for details)*
Screener accessibility	*See requirement*	• Requirement that Networks offer both in-person and virtual Screening capacity outside business hours, including after 5 PM on weekdays & weekends • Requirement for Networks to offer both in-person and virtual Screening capacity, including phone, video, and web (though payment will not be made for Self-Screens that do not have a 1:1 interaction between member and a Screener). Screenings should not be conducted through text message or automated tools (e.g., robocalls); however, members can be navigated to an online Screening Tool via text message
SCN Function: HRSN Service Delivery		
Service delivery capacity	*See requirement*	Required minimum **85%** of referrals made to organizations are accepted[3] within **5 business days**
Service delivery continuity	*See requirement*	*No requirement at start of program:* The % of referrals accepted for which service delivery is started will be monitored throughout the waiver; OHIP expects that SCNs strive to deliver services within a reasonable time frame
Network characteristics	*See detailed guidance immediately following table*	
Network inclusivity	*See detailed guidance immediately following table*	

[1] Member has received and acknowledged receipt of communications requesting an Eligibility Assessment

[2] Identified unmet HRSN includes indication from member that they want to receive services

[3] The Organization in the Network that gets a referral accepts the member and commits to providing / delivering the HRSN service

iii. Characteristics of SCNs

HRSN service providers will screen Medicaid members for HRSNs, navigate members to appropriate services, and deliver HRSN services. Entities are required to be part of the Network if they wish to receive reimbursement from the SCN Lead Entity for providing Screening, Navigation, and/or Enhanced HRSN Service Delivery.

OHIP intends for SCNs to include organizations representing the populations of the communities served. As such, OHIP expects that SCN Lead Entities comprise their region's Network with organizations and entities according to the following guidelines:

- *Organizational type (non-profit vs. for-profit)*: OHIP intends for Networks to be comprised primarily of non-profit entities. There may be situations in which SCNs cannot ensure sufficient capacity with existing non-profit entities. SCNs may include for-profit entities where necessary to support access provided that the SCN has already fully considered and included available non-profits capable of meeting OHIP requirements. SCNs are expected to communicate to OHIP the rationale for inclusion of a for-profit entity. OHIP does not need to approve each individual for-profit entity to be included in the SCN; however, OHIP reserves the right to request additional information or clarification on inclusion of a for-profit entity and to request they be excluded from the Network in the event that non-profit alternatives are able to deliver Enhanced HRSN Services. Preference should be given to non-profit organizations. SCNs should track and monitor that non-profits are receiving the majority of referrals (as their capacity allows)
- *Organization size:* OHIP intends for Networks to be comprised of organizations that vary in size. SCNs are encouraged to build Networks that reflect the diversity of entities in their region (e.g., including organizations with an annual budget of less than $5 million)
- *Organizational competencies:* OHIP expects SCNs to ensure all members in their region have access to Screening and Navigation in a timely manner using the member's language of choice and individual accessibility considerations

iv. Language competencies for SCN organizations

Each SCN must have language competencies aligned with the languages that are common and preferred by Medicaid populations of the region. This will be informed by a recent NY State of Health report on the preferred written and spoken language of enrollees, as provided to SCNs by OHIP.

As of the June 9, 2024, NY State of Health report, the ten most common preferred written and spoken languages, other than English, by the Medicaid population across New York are: Spanish, Mandarin Chinese, Russian, Cantonese, French, Haitian Creole, Korean, Arabic, and Bengali.

SCNs may have individuals on staff with necessary linguistic competencies, or may contract with interpreter services as needed, or both. SCNs are responsible for planning Screening capacity accordingly and reporting to OHIP the specific language capabilities within the Network on an ongoing basis.

SCN Lead Entities should ensure the Network can be responsive to individual member needs, including people with disabilities and with specific religious or cultural preferences. OHIP expects SCNs to operate in accordance with National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).

v. Accessibility of Enhanced HRSN Services

OHIP expects SCN Lead Entities to establish a Network of HRSN service providers that is able to meet the unique needs of members across an SCN region. While OHIP is not establishing HRSN service delivery requirements for distance and accessibility, as additional data and information is collected through service provision, OHIP may introduce additional specific requirements. Initial guidance includes:

- *Distance to service provider:* SCNs should ensure sufficient geographic coverage to minimize travel distance required for members to receive services

- *Service accessibility:* Enhanced HRSN Services should be provided in appropriate accessible formats (e.g., virtual and in-person as appropriate)

vi. Ensuring broad and inclusive Social Care Networks

To best address the needs of underserved and hard-to-reach populations and ensure choice for members, OHIP expects that SCNs will include a wide variety of organizations within each region that serve Medicaid members.

All interested and eligible organizations should be able to join the Network if there is a reasonable role they can fill, including the HRSN service providers providing HRSN services as well as health care providers and other organizations.

OHIP will establish a dispute process through which any interested organization with a reasonable role to serve within the SCN can report their exclusion from the Network. Guidance on specific processes for disputes will be defined in coming months.

- *HRSN service providers:* OHIP expects SCNs to include all HRSN service providers in the designated region that provide Enhanced HRSN Services and who want to join the Network. In addition, SCNs are expected to conduct outreach to HRSN service providers that are already grantees of New York State who are providing Enhanced HRSN Services to invite them to be part of the Network. OHIP will provide a list of relevant grantees to SCN Lead Entities
    - These HRSN service providers may include voluntary foster care agencies (VFCAs), childcare resource and referral (CCR&R) agencies, and other grantees of the Division of Family Health, the Division of Chronic Disease Prevention, and the Division of Nutrition that are running programs providing HRSN services (e.g., WIC, Child and Adult Food Care Program, food banks, emergency food relief organizations, asthma prevention programs, nurse-family partnerships, family planning providers, early intervention, Children and Youth with Special Health Care Needs program)
- *Health care providers:* OHIP expects that SCNs will work with all interested health care providers that serve Medicaid members in each region as well as entities that coordinate care (e.g., Health Homes, Patient-Centered Medical Homes). SCNs should be inclusive of a variety of provider types, including major hospitals, primary care practices, health centers, behavioral health providers, and other entities providing care to the Medicaid population in each region
- *Other entities:* SCNs may engage with additional entities to ensure a robust Network, including but not limited to local Departments of Social Services, schools or school districts, Head Start programs, local departments of health and mental health, local housing authorities, HUD Continuum of Care (CoC) partners, and other government or non-government entities. Note that government entities may not be reimbursed for Screening, Navigation, or Enhanced HRSN Service delivery

In the event of consistent underperformance by HRSN service providers, health care providers, or other entities, SCN Lead Entities may disenroll them from the Network.

vii. HRSN service provider & ecosystem partner complaints

In the event that a stakeholder interacting with the SCN Program has a complaint related to engaging with the SCN program (e.g., exclusion from the SCN, issues with payments for Enhanced HRSN Services, etc.), OHIP encourages the stakeholder to communicate their complaint with the relevant SCN Lead Entity.

However, at any time, stakeholders such as HRSN service providers or ecosystem partners may submit a complaint directly to OHIP. In this case, OHIP will follow the process below:

Table 4-2: OHIP Complaint Review Process

Step	Details
1: Stakeholder submits complaint to OHIP	• Stakeholders may submit complaints via email to SDH@health.ny.gov • Stakeholder complaints should include the following: • Name of the organization submitting the complaint • Name of the SCN Lead Entity involved in the complaint • A narrative description of the complaint • Timeframe of when the complaint occurred
2: OHIP reviews and resolves complaint	• Upon receipt of the complaint, OHIP will: • Review the complaint • Engage the relevant SCN Lead Entity to resolve complaint
3: OHIP shares path to resolution with stakeholder	• OHIP may share a response to the stakeholder originally submitting the complaint that outlines an aligned resolution or path to resolution, as needed

viii. Expectations for infrastructure funds and capacity building

Overview of infrastructure funding: OHIP expects SCNs to support capacity building for CBOs within the Network. SCN Lead Entities will receive infrastructure funding to support development of the Network. Infrastructure funds are used directly by the SCN Lead Entity and distributed to CBOs (CBO capacity building funds).

Use of infrastructure funding for onboarding to the SCN IT Platform and technical assistance: SCNs should use infrastructure funding to assist entities that are contracted with the SCN to provide access and onboarding to the IT platform and training. In addition to funding, SCN Lead Entities are responsible for providing onboarding support to contracted organizations in the Network for the following topics as needed:

- Setting up and using the SCN IT Platform
- Conducting HRSN Screenings using the AHC HRSN Screening Tool
- Completing Eligibility Assessments and Social Care Plan development
- Tracking referrals, service provision, and service completion
- Ongoing technical assistance

Capacity building funds for CBOs

Distribution and eligibility for CBO capacity building funds: CBO capacity building funds may only be distributed by SCN Lead Entities to not-for-profit 501(c)(3) or 501(c)(4) charitable organizations that work at the local level to meet community needs and provide HRSN waiver services to members. SCN Lead Entities will determine distribution of capacity building funding across eligible CBOs that meet this definition. SCN Lead Entities should ensure that CBO capacity building funding is distributed to build CBO capacity across a diverse set of CBOs in the Network. Information on capacity funding and its uses should be shared with CBOs upon initial engagement or shared alongside information about joining the Network. As a best practice, a method or process for obtaining capacity dollars should be provided to eligible CBOs with or upon the execution of the SCN-HRSN provider agreement.

OHIP ***strongly*** encourages SCN Lead Entities to create efficient, accessible processes to distribute capacity building funding to CBOs (e.g., sharing clear information on requirements to obtain capacity building funding at the start of the contracting process, using a simple application with clear criteria for receipt of funding).

Lead Entities may choose to make a portion of a CBO's capacity building funding award contingent on CBO operations / performance to encourage CBO scale-up (e.g., contingent on the achievement of certain milestones).

OHIP requirements for uses and tracking of funds (outlined in Table 7-1 *Allowable uses of infrastructure funding and eligible organizations*) apply to all funds distributed to Lead Entities, regardless of whether funding is contingent on performance.

Health systems or other health care providers as defined in this Manual, clinics, behavioral health clinics, federally qualified health centers (FQHCs), Certified Community Behavioral Health Clinics (CCBHCs), MCOs, local departments of health, and for-profit entities are NOT eligible for CBO capacity building funds, but may be eligible for capacity building funds for healthcare providers and behavioral health providers (see below for more information). Health Homes run through FQHCs, behavioral health clinics, and health systems are eligible for CBO capacity building funds, as long as the Health Home meets the criteria outlined below.

Health Homes and Care Coordination Organizations

Health Homes and Care Coordination Organizations (CCOs) may receive capacity building funds if the following criteria are met:

- They have a 501(c)(3) or 501(c)(4) status **and either** of the following:
    a. They have a separate line of business that will provide HRSN Services which is operated in a separate division or unit from the portion of the business that is billing for Health Home Services; the line of business providing HRSN services must have separate books and records, staff, and management from the Health Homes business or are contracted with a SCN to receive referrals outside of the Health Home members from the SCN; **or**
    b. Health Homes and CCOs may receive capacity building funds to hire, onboard, provide equipment to, and train full or part-time staff (Social Care Navigators) if they provide Screening, Navigation and Enhanced Care Management to Health Home/CCO members and non-Health Home members that meet the enhanced (level 2) eligibility criteria

In general, Health Homes and CCOs may apply for capacity building funds on behalf of the separate line of business providing HRSN Services. The line of business that receives and uses the funds must use the funds

towards delivering HRSN Services to members. This includes Health Homes run through FQHCs, behavioral health clinics, and health systems as long as the Health Home meets the above criteria. Care management agencies may receive capacity funding if they have a 501(c)(3) or 501(c)(4) status.

Allowable use of CBO capacity building funds: Allowable uses of funds for capacity building include direct funding to non-profit organizations, such as:

- Onboarding, training, and salaries for full- or part-time staff who provide services (e.g., conducting outreach to members, providing screenings & navigation)
- Procuring equipment or technology required to launch or scale services
- Investing in office space or operational needs tied directly to service delivery
- Enabling program planning and development directly related to enhanced HRSN services

CBOs may receive both capacity building funds as well as payments for the delivery of HRSN services to individual members.

OHIP encourages SCNs to use the following practices with regard to distribution of capacity building funding to CBOs:

- Providing upfront funds to cover time related to training, equipment, and start-up expenses
- Allowing up to 12 months of salary and fringe for FTEs dedicated to the SCN HRSN Services as the volume of service payments ramps up
- Assisting CBOs with calculating how the referral volume and rate will sustain staffing and overhead

10 business day. SCNs are expected to report components of their CBO capacity building in the Infrastructure Cost Report (*See SCN Reporting*).

Capacity building funding for healthcare providers (HCPs) and behavioral health providers

SCNs may distribute infrastructure funds to healthcare providers—including hospitals, health systems, physician offices, FQHCs, and behavioral health providers—to hire FTE Social Care Navigators. The purpose of this funding is to increase the number of Medicaid members in different care settings with access to HRSN services.

Capacity building funds may be used for the salary and fringe benefits of an FTE Social Care Navigator who solely works on the SCN program. These FTEs must be trained and onboarded onto the SCN IT Platform. SCNs will only fund providers who serve high-needs populations in underserved communities (e.g., using hotspot data) and whose patient population consists of at least 30% Medicaid members within their practice. Navigators must conduct screenings, eligibility assessments, make referrals, and provide Enhanced Care Management to members. Providers are also permitted to use their EHR to conduct the AHC screening and within the same day have the navigator provide the members assessment and referral in the SCN IT Platform. The Navigators are required to meet the SCN's goals and metrics as criteria for receiving funding. Funding may also be used as incentive or bonus payments for meeting metrics and goals set by the SCN.

Providers participating in the Medicaid Hospital Global Budget Initiative are not eligible to receive capacity building funds. Documentation requirements for healthcare provider capacity building funds align with those of CBO capacity building funds.

b. GOVERNANCE REQUIREMENTS

Both when SCNs are initially launched and as they grow and mature over time, it is essential that SCN Lead Entities have a way to receive feedback from Network members and other community partners, align on shared priorities and strategic goals, and collaboratively make or approve important operational decisions. To achieve this, SCN LEs must issue the OHIP-provided, "HRSN Service Provider Survey" to their network on an annual basis and share the final survey results with OHIP and their governing body for discussion, improvement, and resolution of issues. The survey is due to OHIP at the end of April every calendar year.

To ensure that all SCNs have clear structures in place to meet those needs, OHIP requires that each SCN Lead Entity create a governing body for its region. Governing bodies should be comprised of a wide array of stakeholders in the region, including (but not limited to) CBOs delivering HRSN services, providers, advocacy organizations, members, and other community members who are representative of the communities served by the SCN. CBOs should comprise the majority of the governing board for each SCN.

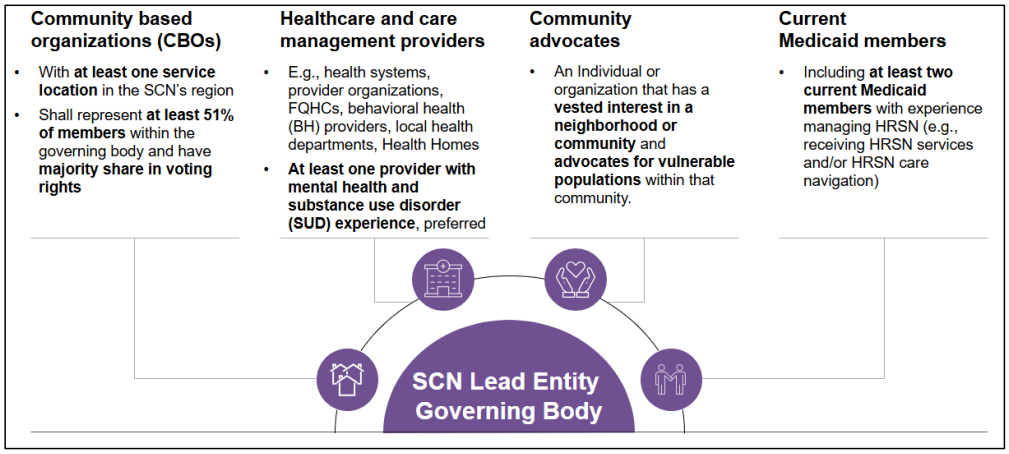
To better understand and address disparities and inequities that can impact Medicaid members' HRSNs and their ability to access HRSN services, OHIP expects SCN Lead Entities to ensure their governing bodies include a broad and regionally representative group of individuals with diverse backgrounds and identities with regard to race, ethnicity, age, disability status, and socioeconomic status.

Before the start of service delivery, the SCN Lead Entity must define a governing body that includes:

- **Community based organizations** providing HRSN services in the SCN's region. CBOs must represent at least 51% (excluding the SCN Lead Entity) of the governing body and have a majority share of voting rights. CBOs must have a service location in the SCN region in order to qualify for this requirement. A CBO may serve on multiple different SCN Governing boards if they provide services in multiple SCN regions
- **Health care and care management providers** (e.g., health systems, providers, FQHCs, behavioral health (BH) providers, local health departments, Health Homes) in the SCN region, and including at least one provider with mental health and Substance Use Disorder (SUD) experience is preferred
- **Community advocates** who are collectively representative of the region and who the SCN serves
- **Current Medicaid members**, including at least two current Medicaid members with experience receiving HRSN services and/or HRSN Social Care Navigation. Note that SCN Lead Entities are not expected to post publicly the names of Medicaid members participating in the SCN Governing Body. Medicaid member names may be posted publicly only if members provide permission, but they should not be identified as a Medicaid member

The SCN Lead Entity will also need to ensure that the governing body follows any requirements for the governing bodies of 501(c)(3) organizations and is convened in routine intervals, at least quarterly.

Figure 4-1: Requirements for composition of members of SCN Lead Entity governing body



c. SCN IT PLATFORM REQUIREMENTS

i. Introduction to Platform Requirements

For an SCN to truly serve as an interconnected Network that identifies and addresses HRSNs, many kinds of data and information need to be shared across organizations.

For example, imagine a primary care provider has a patient who is a current Medicaid member with complex health conditions. They screen the member for HRSNs and learn that they are food insecure. The provider needs to share those Screening results with the SCN. A Social Care Navigator within the SCN needs to review the Screening and conduct an Eligibility Assessment to determine whether the member is eligible to receive Enhanced HRSN Services. Once the Social Care Navigators determines the member is eligible, they will need to refer to the appropriate HRSN service provider who can provide the right HRSN service. The HRSN service provider who receives that referral needs to know what HRSN services the member is eligible to receive. The SCN Lead Entity needs to pay the HRSN service provider for delivering the service. OHIP needs to know what services were provided and whether they impacted the member's health outcomes and costs.

For that information to be exchanged in a seamless and timely way, it is critical that each SCN has a shared technology infrastructure that allows organizations in the Network to send and receive information.

Rather than mandate the use of a specific technology platform, OHIP is giving SCN Lead Entities the flexibility to each implement an SCN IT Platform that is the best fit for their region's needs. SCN IT Platforms will all be required to have certain features and meet specific requirements described in this section.

As SCNs will be comprised of a wide variety of organizations, with varying levels of administrative capacity and experience with similar technology, OHIP encourages SCN Lead Entities to prioritize creating a platform that can provide an easy, intuitive, and efficient user experience for the Network.

ii. Platform Functionality

One comprehensive platform or seamless integration of multiple technologies: All SCN Lead Entities must have an SCN IT Platform that enables core responsibilities of the SCN, including Screening, Eligibility Assessment, Navigation, Network management, and fiscal management.

To achieve this, SCN Lead Entities have the flexibility to take either of two different approaches to providing a SCN IT Platform for their region:

1. Contract with **one comprehensive SCN IT Platform** that meets all technical and functional requirements in a single system
2. Contract or subcontract with **multiple technologies / systems** that collectively meet all technical and functional requirements and are seamlessly integrated and managed centrally

Each SCN Lead Entity must ensure that its SCN IT Platform has the capability to meet the requirements of the Key Product Features below. If an SCN's IT Platform does not meet those requirements, the SCN Lead Entity should meet with OHIP to establish a plan to address any unmet requirements, which may include the use of a different platform to meet the requirement of the NYHER program.

iii. Key Product Features of SCN IT Platforms:

Please note additional details may be found in the Platform Resource Pack.

Member information: Display member information (e.g., member contact information, member's MCO details) and eligibility for Enhanced HRSN Services. Member information displayed should vary depending on users' authorization level

User roles, access, and compliance:

- Different organizations in the SCN require unique user roles based on their responsibilities. This is often referred to as "Role Based Access Controls." The SCN Lead Entity is required to manage SCN IT Platform user roles, including assigning appropriate levels of access and responsibility within the SCN IT Platform. Users should only have access to the minimum necessary information to perform their tasks as assigned
  Examples:
  - The HRSN service provider providing a service does not need the same level of access as a Social Care Navigator performing an Eligibility Assessment where they may need access to sensitive health information to determine Eligibility. An HRSN service provider installing handrails doesn't necessarily need information about diagnoses and eligibility status; the service provider only needs enough information to install handrails that meet the need of that Medicaid member
  - The HRSN service provider also does not need access to information about Medicaid members for whom it does not provide case services
- The SCN Lead Entity must ensure users are verified against unique identifiers and access control is limited to the minimum necessary to accomplish the necessary tasks (e.g., Eligibility Assessment)

- The SCN Lead Entity will also ensure that SCN IT Platform users have met Screening / referral training requirements

Screening:

- Enable users to screen members using a standardized embedded Screening Tool (i.e., AHC HRSN Screening Tool), enable near-real time member-level updates to Screening status, and results. The Platform should also be able to capture and track member consent
    - Support terminology and the minimum viable data set
    - Exhibit FHIR competency

Eligibility Assessment:

- Enable a user to determine member eligibility for receiving Enhanced HRSN Services by ensuring logic from Table 5-13, Table 5-14, Table 5-15, and Table 5-16 is automated for Eligibility Assessments and Navigation workflows. The SCN IT Platform must apply this logic for eligibility criteria for enhanced populations, clinical criteria, and Social Risk Factors to offer a timely and efficient user experience that limits options for referrals only to the HRSN domain and applicable sub-services the member is eligible for and addresses the member's identified unmet HRSN. Based on the unmet need screened and the Eligibility Assessment, the platform should suggest appropriate HRSN service providers. For example,
    - If a member is not eligible for any Enhanced HRSN Services, no enhanced service providers should be displayed
    - If a member is only eligible for Medically Tailored Meals, only Nutrition providers that provide that particular service should come up
- Enhanced HRSN Services are for Medicaid Managed Care members in an Enhanced Population that have an identified unmet HRSN and wish to receive services
- Members with an identified unmet HRSN who are not eligible for Enhanced HRSN Services may be navigated to existing federal, state, and local services. Navigation to existing services may be completed for both Medicaid FFS and Medicaid Managed Care members that do not meet the criteria for Enhanced HRSN Services. Members who are eligible for Enhanced HRSN Services may also be navigated to existing federal, state, and local services
- The SCN IT Platform should also be able to capture and track member attestation for the accuracy of information provided throughout the Eligibility Assessment
- The SCN IT platform must retain all historical member data within the system for at minimum 10 years, including any initiated, partially completed or completed Eligibility Assessments, unless intentionally changed or deleted by the SCN Lead Entity or their contracted Social Care Navigators

Closed Loop Referrals for Enhanced HRSN Services:

- A Closed Loop Referral means that the Social Care Navigator who referred a member for Enhanced HRSN Services can see the status of the referral and knows whether the service was provided. The SCN IT Platform must conduct and manage Closed Loop Referrals and service coordination with HRSN service providers. This includes tracking:
    - Enhanced HRSN Services a member is referred to
    - Which HRSN service provider the referral was sent to and who has accepted the referral
    - Status of the referral (e.g., open, closed)
    - Time to Closed Loop Referral

- Details on services delivered (e.g., type of intervention, duration)

Coordination of health and social care:

- Allow input of notes to support service coordination by health and social care professionals (e.g., Social Care Navigators, case managers, providers)

Licenses:

- The SCN Lead Entity will obtain licenses for all participating entities including MCOs, providers, and HRSN service providers

Payment and fiscal administration:

- Draw upon each SCN's HRSN Fee Schedule for services delivered, enable generation of social care claims, and track reimbursements

Performance management:

- Generate supporting information (e.g., performance dashboards) for SCN quarterly performance reporting requirements to OHIP and enable continuous improvement activities across SCNs

Data sharing and exchange:

- Facilitate bi-directional exchange of data with SHIN-NY (which will play a central role in SCN program operations) and enable near real-time data sharing across key program stakeholders. SCN IT Platforms should be able to incorporate eligibility files from MCOs via the SHIN-NY and into the SCN IT Platform to support the Eligibility Assessment process. (For 1115 SHIN-NY Interoperability Guidance, SCN Lead Entities and their SCN IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/)
- Include support terminology and the minimum viable data
- Exhibit FHIR competency

The table below outlines features that SCN IT Platforms are expected to have and examples of standard data elements that should be generated and shared amongst stakeholders, primarily via SHIN-NY. SCN Lead Entities may build in additional functionalities for their SCN IT Platform as relevant for their Network and regional needs. The SCN Lead Entity must define data sharing requirements in a Service Level Agreement (SLA) they establish with their SCN IT Platform vendor. Additional guidance on platform functionalities is maintained in the Platform Resource Pack (PRP).

Table 4-3: SCN IT Platform features and functionalities

Category	Minimum features / functionalities
Member information	• Display member information / profile (e.g., member identifier, demographics, contact information, MCO name / ID) • Display eligibility for Enhanced HRSN Services and allow certain users to modify / update eligibility status • Capture and track member consent for sharing of HRSN data

Category	Minimum features / functionalities
	• OHIP has developed a minimum viable dataset (MVD) that will be utilized to ensure specific data elements needed for Medicaid capture, analysis, and CMS reporting are being sent by the organizations involved in the 1115 Waiver. The MVD includes member and organization attributes needed during each HRSN data step including Screening, Assessment, and referrals • (*For more information on 1115 SHIN-NY Interoperability Guidance, visit the NYeC Website 1115 Waiver support website*)
Compliance and user access	• Authenticate SCN IT Platform users by ensuring they have completed SCN IT Platform and Screening / referral training requirements
Screening	• Embed AHC HRSN Screening Tool • For each member, reflect latest and historical Screening status / HRSNs and results (via SHIN-NY subscription). SCN Lead Entities will incorporate a weekly extract from the SHIN-NY into the SCN IT Platform allowing the ability to query to determine member Screening status • Allow authorized users to view and update Screening results, as needed • Display which HRSN service providers in the Network provide HRSN Screenings and Enhanced Services • Screening and HRSN data for non-Medicaid members may be shared but is not required (Screens of non-Medicaid members will not be reimbursed) • Ingest and display screenings conducted outside the SCN IT Platform (e.g., off-platform screenings)
Eligibility Assessment	• The user will be asked to answer a standard list of questions to confirm identity, enrollment, and HRSNs. Allows Social Care Navigators to select appropriate ICD-10 z-codes and SNOMED-CT description for a member's unmet HRSNs. The Social Care Navigator will confirm member's desire for services and check the Enhanced Services Member File, and evaluate duplicative services that the member and / or the household may also be receiving
Referral and service delivery	• Maintain up-to-date, accurate, and publicly available HRSN service Resource Directory (e.g., name, location, EIN, services provided, contact information) • Conduct Closed Loop Referrals to organizations within the SCN that deliver Enhanced HRSN Services. Referral details should include HRSN services for which referral was made, which HRSN service provider a member was referred to, whether referral is open / closed, time from when referral is made to when service delivery is initiated, and any specifications of the service Allow input of the Eligibility Assessment and case notes related to social care into a Social Care Plan and sharing of case notes (as needed) with MCOs and providers • Track completion of services and service details to inform coordination and generation of invoice / claim for services

Category	Minimum features / functionalities
	• Track current and historical member service delivery experience details (e.g., prior services delivered to member and associated details) • Maintain ability to incorporate external provider directories (via application programming interface with MCOs) • Capture and share information with Social Care Navigators on ability of HRSN service providers to receive referrals and provide Enhanced HRSN Services based on their capacity
Payment and fiscal administration	• Generate social care claims including service detail • Track status of claims submission and process electronic data interchange transactions • Track HRSN Fee Schedule-based reimbursement from SCN Lead Entities to entities within the Network • Maintain up-to-date HRSN Fee Schedule to inform claims generation
Performance management	• Generate performance reports that meet State requirements • Generate Network-level summary data (e.g., number of participating HRSN service providers, activity by HRSN service provider, summary of services delivered, etc.)
Data sharing and exchange	• Conduct near real-time and batch bi-directional exchange of data with SHIN-NY (through subscription query capability) • SCN Lead Entities and their SCN IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/ • Incorporate eligibility files from OHIP (MEF) and MCOs (ESMF) via the SHIN-NY and incorporate them into the SCN IT Platform for the Eligibility Assessment process
Privacy and Security	• SCN Lead Entities must meet federal and state laws, regulations, and security provisions outlined in the OHIP Moderate-Plus Security Controls Baseline • The importance of privacy and security cannot be overstated. Upon execution of the contract, SCN Lead Entities will systematically strengthen data privacy and security and will need to meet with Security and Privacy Bureau to ensure security and privacy compliance *(For additional details on privacy and security, see Data Privacy and Security*)
"Urgent" or "high priority" flags	• Optional: OHIP encourages SCN IT Platform functionality that allows providers to flag a member's needs as "high priority" (e.g., meeting HRSN is required as part of hospital discharge). SCNs who have this capability within their SCN IT Platform can make use of this feature. SCN Lead Entities should define proper protocols and procedures for "high priority" flag usage and communicate these instructions to providers

iv. Background on Coding Granularity

During the Eligibility Assessment and when making referrals, Social Care Navigators will be required to select granular ICD-10 and SNOMED-CT description of a member's unmet need. ~~This will capture the specific nature of Navigation support provided by the Social Care Navigators and specific enhanced HRSN services to which members are referre~~ Following the Eligibility Assessment, Social Care Navigators will also be required to select granular ICD-10 and SNOMED-CT to capture the specific nature of Navigation support provided and specific Enhanced HRSN services to which members are referred.

Per the Social Care Coding document, OHIP recognizes that this coding will require additional time for Social Care Navigators to input. Accurately coding Navigation activities and HRSN service referrals is critical for both SCNs and OHIP to conduct ongoing monitoring of SCN activities, including accurately tracking referrals to and spend on various services, and to enable long-term program sustainability. In addition, granular coding will enable evaluation of the impact of the SCN program and inform design of subsequent HRSN programs and risk scoring methodology.

Wherever possible, OHIP encourages SCNs and SCN IT Platform vendors to automate filtering logic by only having relevant coding available based on previous steps in the workflow to ensure time required from Social Care Navigators is minimized.

Social Care Coding Automation and Display in SCN IT Platforms: The SCN IT Platform shall auto-populate a filtered set of coding options for each of the Eligibility Assessment and Navigation activities (e.g., referral and delivery of Enhanced HRSN services) based on the member's specified needs as identified via the AHC HRSN Screening Tool.

Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the most current Social Care Coding document referenced below or via NYeC's NYHER 1115 Extranet.

Eligibility Assessment

ICD10/SNOMED coding

- The SCN IT Platform should populate only the ICD-10 and SNOMED-CT assessment code(s) description(s) associated with the member's unmet HRSN Screening response(s) in the Eligibility Assessment for the Social Care Navigator to select from
    - For example, if the member's HRSN Screening demonstrates a positive need for "Mold" (Question #2 response) and "Help keeping work" (Question #7 response), the platform should only suggest codes "Other inadequate housing" (Z59.19)/"Mold growth in home" (224255009) and "Unspecified problems related to employment" (Z56.9)/ "Employment problem" (75148009), respectively for the Social Care Navigator to document. Other coding options should not be populated given no other unmet HRSN identified
    - Please reference the NYeC Extranet to view the latest Excel "Social Care Coding", "Screening to Assessment Mapping" tab. The public posting is also available here: https://nyehealth.sharepoint.com/:x:/s/NYHER1115Extranet/IQAyQISWdXc_RqHmyzviwG1AAeln2BTwIfCe-VNYEHjx0mI?rtime=dTr5YDFY3kg
    - The IT Platform should use the same description and code strings for ICD10 and SNOMEDCT assessment code options as they appear in the "Social Care Coding", "Assessment- ICD & SNOMED" tab

Social Care Navigation

SNOMED coding

- The SCN IT Platform must first consider whether the member is eligible for Navigation or Enhanced Services before making a recommendation on HRSN services (*see criteria in Table 5-4: Populations eligible for Navigation and Enhanced HRSN Services*)
    - Members who are assessed to be eligible for Navigation should be offered the following per the "Social Care Coding" workbook:
        - All Navigation SNOMED codes found in the "Services-SNOMED" tab
    - Members who are assessed to be eligible for Enhanced Services should be offered the following per the "Screening to Services" workbook:
        - All Enhanced Care Management Services within the red box in the "Care Management" tab
        - All Enhanced Care Management Services in the "Care Management" tab associated with the specific questions to which the member screened positive (i.e., listed below the red box)
        - All HRSN service SNOMEDs associated with each positive Screening response for the member (located on the domain-specific "Housing," "Nutrition," and "Transportation" tabs)
            - For example, if the member's Screen demonstrates a positive need for "Mold" (Question #2 response), in addition to the relevant Care Management options, the following five domain-specific services should be offered with the respective SNOMED codes

Please reference the NYeC Extranet to view the latest Excel "Social Care Coding" and "Screening to Services Mapping" documents for all coding guidance. The public posting is also available here: https://nyehealth.sharepoint.com/:x:/s/NYHER1115Extranet/IQAyQISWdXc_RqHmyzviwG1AAeln2BTwIfCe-VNYEHjx0mI?rtime=dTr5YDFY3kg

For detailed requirements, see Data Sets, Terminologies, and Coding

v. Data Sharing - Interoperability

For HRSN data to be efficiently shared across many organizations and entities, it is important for there to be common data standards (e.g., shared terminology and coding, shared data quality expectations) and interoperability between any systems that are sending and receiving SCN data.

SCN Lead Entity responsibilities include:

- Agree to share data elements as defined in the minimum viable data set with the QE and send data to the QE who will then submit data on behalf of the SCN Lead Entity to the NYeC/SHIN-NY data lake
- In coordination with a QE, establish a user process and technical means to obtain data from the SHIN-NY via a real-time API call to the SHIN-NY data lake
- Ensure the SCN IT Platform vendor can display Medicaid member files and flag eligibility (e.g., member information, Enhanced Services eligibility)
    - Medicaid Eligibility files will be sent from the SHIN-NY to SCN Lead Entities

- Consensus-based terminology and coding standards for social care and payment data including, but not limited to, LOINC codes, ICD-10 Z-codes, SNOMED-CT codes, HCPCS codes, CBO identifiers (e.g., TIN)
- Ensure SCN IT Platform ability to submit Social Care Claims to MCO in a format that meets HIPAA post-adjudicated claims standard (i.e., 837 EDI transaction) for payments
- Meet HL7 FHIR national standards for bi-directional data sharing and data transactions between the SCN Lead Entity and QE in accordance with 1115 SHIN-NY Interoperability Guidance
- Define approach to aligning data quality standards and validation processes with existing federal and state data standards

For detailed requirements, see Data Sharing – Interoperability

vi. Data Governance, Privacy, and Security

In accordance with the participation agreements established among key stakeholders—including the SCN Lead Entity and regional QE, as well as the SCN Lead Entity and MCO—all participating entities are mandated to adhere to the SHIN-NY data privacy and governance policies and guidelines issued by OHIP.

(*For detailed requirements, see Data Governance, Privacy, and Security*)

d. TRAINING EXPECTATIONS

SCN Lead Entities are responsible for ensuring that all SCN employees, HRSN service providers, other entities in the Network, and MCOs (if MCOs choose to participate in Screening, Eligibility Assessments, and / or Navigation) are appropriately trained to serve Medicaid members either through trainings provided by the SCN Lead Entity or through other means. SCN Lead Entities are expected to develop specific and comprehensive curricula that are responsive to the needs of their population. They can also enlist vendors to meet these needs or use train the trainer models.

Training should be relevant to the contracted provider's role within the Network (e.g., Screening, Navigation, HRSN service provision). Individuals, health care providers, behavioral health providers or specialized CBOs can opt out of a training if they can attest that they have already taken or provided the needed training. The training modality is at the SCN Lead Entity's discretion. The length of time it takes to complete trainings provided by an SCN Lead Entity for an individual should not exceed 30 days. SCN Lead Entities should ensure entities in their Network receive and complete training across the following topics as relevant for each stakeholder:

The following two trainings are required as part of the onboarding process.

- *Technology training:* Instruction on how to use the SCN Lead Entity's SCN IT Platform (including to MCOs if the MCO chooses to utilize the SCN IT Platform) – not applicable if using an independent platform for Screening
- *Care delivery functions*: Instruction on the Care Delivery Approach outlined in this Operations Manual should be determined by the SCN Lead Entity in consideration of the contracted role and service an individual will be providing

The following training is **required**, but entities can be onboarded and start providing services prior to completion.

- *Cultural and linguistic training:* Instruction on being responsive to members' diverse beliefs, practices, communication disabilities (e.g. vision, hearing or speech) and needs *(For additional details on ensuring appropriate language access, see HRSN Network Capacity and Access)*
- *Trauma-informed training:* Instruction on the impact of trauma and how to integrate trauma-informed approaches in work with vulnerable populations
- *Optional based on need - Population-specific training:* Instruction on engaging with specific subpopulations including but not limited to:
    - Children and families, including those involved with foster care or child welfare systems
    - Members with Intellectual and Developmental Disabilities (I/DD)
    - Members with Behavioral Health conditions, including Serious Mental Illness (SMI) and Substance Use Disorders (SUD). Trainings should include policies on de-escalation techniques.
    - Criminal justice-involved populations, including justice-involved youth

Child abuse and neglect: OHIP expects SCN LEs to ensure Screeners, Social Care Navigators and Enhanced HRSN service providers working with children and youth in their Network undertake appropriate training and/or equip Social Care Navigators to report child abuse or neglect, as needed. Social Care Navigators are expected to report or cause a report to be made when they have a reasonable cause to suspect that a child is abused or neglected. Social Care Navigators who interact with children/youth and families must take the 2-hour web-based online training course: New York State Mandated Reporter Resource Center - Home (nysmandatedreporter.org) SCN Lead Entities must also provide their Conflict of Interest (COI) Plan to their Network and any necessary trainings to implement and action on their COI Plan.

Reporting on training expectations: SCN Lead Entities will have the opportunity to report on training activities to date in the *Network Composition Plan and Report as well as the Quarterly Performance Report (Narrative) (for more details on reporting guidelines, see SCN Reporting).* SCN Lead Entities, prompted and facilitated by OHIP, may also be asked to share their best practices across regions. OHIP reserves the right to adjust training requirements and guidelines.

e. SCN PUBLIC WEBSITE

The SCN Lead Entity will provide and maintain a public website capable of offering Screening and providing information on the Network on or before January 1, 2025, as indicated in the SCN Lead Entity's contract with OHIP.

The SCN public website is expected to include:

- *Basic introduction to SCN and services offered:* Guidance to public audience on services provided by the SCN and member eligibility
- *Enhanced Population criteria, clinical criteria and social risk factors for Enhanced HRSN Services:* Information should either match or directly link to information posted on the DOH website under "HRSN Services Eligibility Summary"
- *Contact information to reach SCN:* SCN should include methods to reach the SCN (e.g., email, phone) and include guidance for the following two audiences that may try to contact the SCN:
    - Organizations seeking to reach the SCN (e.g., HRSN service providers, health care providers, MCOs, other entities)

    - Members seeking to reach the SCN (e.g., seeking Screening information, support with accessing SCN resources)
- *Network organization directory:* Up-to-date, publicly available SCN directory that includes all contracted HRSN service providers (*see SCN Reporting for details on data elements that must be included in the quarterly Network Composition Report*)
- *HRSN Screening locations:* Relevant contact information for each Screening location (e.g., address, hours, languages spoken, Screening modalities offered, etc.)
- *Self-Screening capability:* AHC HRSN Screening tool for members to conduct a Self-Screen must be available on the SCN website, and SCNs could consider placing a link to the Self-Screening tool on the SCN website's landing page so it is easy to access for members (i.e., members should not have to click through multiple pages to find the link to the Self-Screening tool). As a best practice, self-screening tools should pull the following data elements into the platform: member's full name, phone numbers, date of birth and identification number; name and TIN/NPI of entity completing the self-screening tool; and name of person completing self-screening tool (if not member) and relationship to member
- *Language translation:* It is up to the discretion of the SCN Lead Entity to determine languages in which key information on the SCN website will be made available. OHIP encourages SCNs to make materials available in the languages that are common and preferred by Medicaid populations of the region (*see HRSN Network Capacity and Access*)
- *Governing body:* The SCN Lead Entity shall post a list of Governing Body members on the SCN website. SCN Lead Entities are not expected to post publicly the names of Medicaid members participating in the Governing Body. Medicaid member names may be posted publicly only if members provide permission, *but they should not be identified as a Medicaid member*. Additional details (e.g., meeting minutes) do not need to be posted on the website (*see Governance Requirements*)

Process for HRSN service provider & Ecosystem Partner complaints: The SCN shall publish how stakeholders can submit complaints (related to exclusion from the SCN, issues with payments, etc.) to OHIP. For additional details, see Section HRSN service provider & Ecosystem Partner Complaints.

In addition to the including the components above, SCN Lead Entities should ensure their Public Website is designed with appropriate accessibility considerations. Accessibility considerations may include descriptive text for hyperlinks, color contrast, embedded documents, appropriately descriptive text for resources, etc. In addition, the Public Website should strive to communicate information in an easy-to-understand format (e.g., leveraging lists when appropriate, appropriate sub-headings, and tables for tabular information, etc.).

f. PUBLIC MATERIALS ON SCN PROGRAM

OHIP has provided SCN Lead Entities with marketing material such as factsheets / explainers and example media (e.g., social media, videos) to help SCNs raise awareness and educate members, HRSN service providers, health care providers (inclusive of behavioral health providers), and other stakeholders about how to engage with SCNs.

To encourage consistent messaging and ensure accuracy, OHIP asks SCNs to leverage OHIP-developed materials in recruiting providers and engaging members (found here on OHIP's SCN page). The marketing toolkits provided have clear direction on areas for customization and co-branding.

All marketing materials that will be shared with members and/or the community require OHIP approval. Materials internal to the SCN Lead Entity's Network (i.e., internal training materials, CBO guidelines) do not need OHIP approval.

5. CARE DELIVERY APPROACH

Care delivery approach sub-sections

a. Introduction

b. Screening
   i. HRSN Screening overview
   ii. Who will conduct HRSN Screening
   iii. Handoffs to SCN for Screening
   iv. Screening methodology
   v. AHC HRSN Screening Tool
   vi. Considerations for interpersonal safety questions asked during Screening

c. Social Care Navigation
   i. Social Care Navigators
   ii. Reimbursement for Social Care Navigation
   iii. Navigation process

d. Eligibility Assessment
   i. Medicaid Member Eligibility
   ii. Eligibility Assessment Process
   iii. Ending an Eligibility Assessment
   iv. Situations in which a member does not respond to outreach for Eligibility Assessment
   v. Considerations for children, youth, and households
   vi. Considerations for criminal justice-involved individuals and justice-involved youth

e. SCN Referrals
   i. Referrals overview
   ii. Referral workflow with SHIN-NY data requirements
   iii. Referral to Enhanced HRSN Services
   iv. SCN Referral tracking
   v. Distribution of Referrals across Network

f. Service Re-authorizations
   i. Overview
   ii. Social Care Navigator workflow for service re-authorization
   iii. Additional guidance for re-authorization of Nutrition services

g. Enhanced Services Member File
   i. Enhanced Services Member File (ESMF) Overview
   ii. Process for creating, sharing, and auditing the ESMF

iii. Information included in the ESMF

h. Changes in Member Medicaid Coverage and Relocation
   i. Changes in member MMC coverage
   ii. Member relocation and change of address

i. Social Care Plan
   i. Social Care Plan overview
   ii. Components of a Social Care Plan
   iii. Considerations for children and youth
   iv. IT Platform functionality to enable Social Care Plans

j. HRSN Services
   i. Introduction to member eligibility and medical appropriateness
   ii. Enhanced Populations
   iii. Social Risk Factors
   iv. Eligibility by service
   v. Criteria for documentation and attestation
   vi. Geographic location of service delivery
   vii. Covered HRSN Services

k. Partnerships
   i. State and local partnerships
   ii. Health Equity Regional Organizations (HERO)
   iii. Proactive member Screening outreach strategies

l. Member Consent
   i. Member Consent for Screening
   ii. Member Consent for Eligibility Assessment
   iii. Member Consent for Referral / Navigation

m. Duplicative Services

a. INTRODUCTION

Core responsibilities of SCNs: OHIP's overarching vision for the SCN program is to build comprehensive statewide infrastructure that enables a consistent end-to-end process for identifying unmet HRSNs, connecting members with unmet HRSNs to services, delivering effective HRSN services, and reimbursing HRSN service providers.

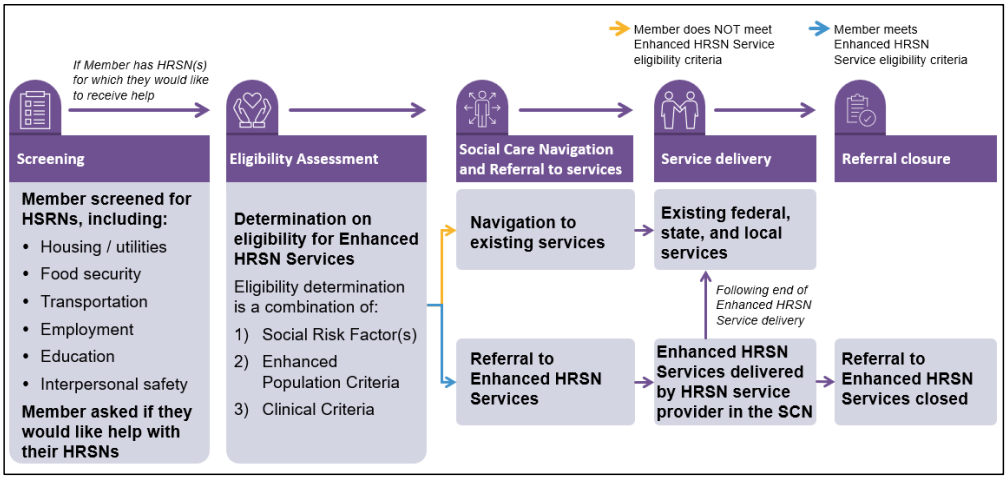
Towards that vision, SCNs are responsible for administering a core set of responsibilities using standardized processes, tools, and partnerships to ensure consistency and equity in how HRSNs are identified and addressed at scale across regions and across many different HRSN service providers.

The core responsibilities of SCNs are:

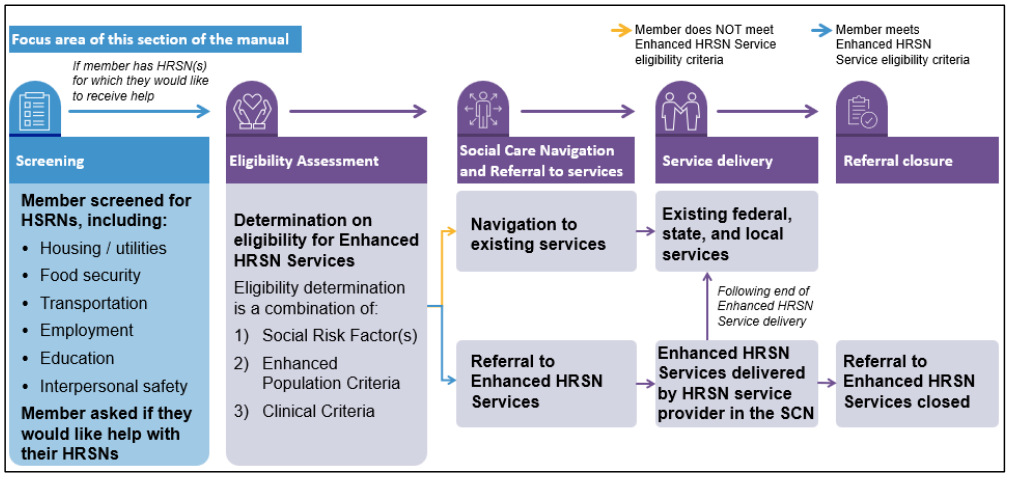
a) **Screen Medicaid members for HRSNs** in a standardized and person-centered way using the AHC HRSN Screening Tool
b) **Conduct Eligibility Assessments** for members whose Screening identifies unmet HRSNs and who request support. Eligibility Assessments will determine whether the member is eligible for Enhanced HRSN Services (Medicaid Managed Care members only) and/or existing federal, state, and local programs (e.g., SNAP, WIC, TANF)
c) **Navigate members appropriately,** including referring eligible members to Enhanced HRSN Services or navigating members to existing federal, state, and local services
d) **Deliver Enhanced HRSN Services** to eligible MMC members
e) **Develop Social Care Plans** that detail member HRSNs for eligible MMC members
f) **Monitor to ensure delivery of Enhanced HRSN Services** and subsequent referral closure

More details on each of these responsibilities can be found on the following pages of this section.

Figure 5-1: Member journey from Screening to Social Care Navigation, service provision, and referral closure



b. SCREENING



i. HRSN Screening overview

Consistently identifying the unmet HRSNs of Medicaid members is the first step to addressing their HRSNs.

OHIP's aim is that every Medicaid member receives an HRSN Screening annually, on a rolling 12-month basis, and on an as-needed basis. Members will be screened using a standardized OHIP version of the AHC HRSN Screening Tool to assess member HRSNs related to housing and utilities, nutrition, transportation, employment, education, and interpersonal safety. Regularly screening members across these domains will improve the identification of HRSNs and show how HRSNs are evolving over time.

There must be sufficient capacity in each region to conduct HRSN Screening for all Medicaid members and for Screening results to be consistently acted on with timely follow-up. The following sections provide details on the role of various stakeholders in HRSN Screening, Screening methodology, use of the standardized AHC HRSN Screening Tool, and reimbursement for Screening.

ii. Who will conduct HRSN Screening

SCN Lead Entities will be responsible for ensuring there is sufficient capacity in their region(s) to conduct Screenings of all Medicaid members. This includes building additional Screening capacity as needed.

SCN Lead Entities are expected to coordinate with partners in the regional ecosystem (e.g., HRSN service providers, health care providers, independent practice associations (IPAs), care management providers, MCOs) to ensure that they have sufficient collective capacity to screen all Medicaid members for HRSNs.

OHIP recognizes that many health and HRSN services providers already conduct HRSN Screenings and encourages continued Screening by these organizations. These organizations are often uniquely positioned in their role as trusted partners to local communities and the ability to reach the Medicaid population.

Screenings conducted using the OHIP-standardized tool by the SCN or other organizations can be used to facilitate Social Care Navigation by the SCN.

MCOs are encouraged to conduct Screening but will not be reimbursed. Please see Section e. MCO Contract Requirements with OHIP, Part iv. MCO Risk Adjustment.

iii. Handoffs to SCN for Screening

OHIP strongly encourages SCNs to work with other stakeholders in the ecosystem to coordinate handoffs of Medicaid members for Screening by the SCN (for example, MCOs are encouraged to establish workflows for MCO care managers to conduct "warm hand-offs" of members to SCN Social Care Navigators). OHIP will not require a specific process for organizations that wish to conduct a handoff to the SCN for a member to be screened. However, in order to facilitate handoffs, SCNs are expected to provide contact information (on an as-requested basis and made publicly available on the SCN website) that external stakeholders can use to contact the SCN to request that a member is screened and to share member contact information.

SCNs should make every effort to follow up with the member and conduct member Screening within five (5) business days of receiving information about the member.

iv. Screening methodology

Screening modality and encounter: To ensure that all members can access Screening according to their needs and preferences, SCNs should offer Screening in different modalities, at accessible times, and in culturally and linguistically competent ways, in accordance with National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

SCN Lead Entities and entities conducting Screening within the Network will agree on the specific modalities, times, languages, etc. in which Screening will be offered. It is the responsibility of the SCN Lead Entity to ensure that the Network overall has sufficient Screening capacity and capabilities.

Screening involves asking a standard series of questions, coupled with the empathetic engagement with individuals to understand their life context, specific needs, and HRSN service preferences. OHIP expects Screeners to treat members with identified unmet HRSNs with care and empathy, including offering time to discuss their needs and potential next steps (e.g., Eligibility Assessment, referral). (*For more information on Screening capacity and capabilities, see HRSN Network Capacity and Access*).

Member consent for Screening data sharing: Entities conducting HRSN Screening are required to receive informed consent from members to share their information and Screening information with the Social Care Network (*for additional information, see Member Consent*). If a member declines to provide consent, the Screening will not proceed.

Screening frequency: OHIP aims to ensure that each Medicaid member will receive a HRSN Screening annually and as needed due to a self-reported major life event *(see Table 5-1)*. A major life event may be identified by any contracted entity within the SCN that is authorized to have direct contact with a member (e.g., through Screening, Eligibility Assessment, or delivery of HRSN services).

SCNs conducting Screening will receive reimbursement for a member's first annual Screening or upon a major life event requiring re-screening. Additional Screenings conducted within a year from the initial Screening (in the absence of a major life event) are NOT eligible for reimbursement.

Table 5-1: Frequency of HRSN Screening

Reason for Screening	Details
Annual Screening	Members will be eligible for reimbursed HRSN Screening annually (rolling 12 months).
Major life event	Members will also be eligible for reimbursed HRSN Screening if a major life event occurs. If the Screener identifies a major life event during their interaction with the member, or if a member was referred to the SCN for a Screening as a result of a major life event, the member may be re-screened within the same year and the Screener may be reimbursed for the Re-screen. A major life event is a permanent or fluctuating event in a member's life that may be identified by any contracted entity within the SCN that is authorized to have direct contact with a member (e.g., through Screening, Eligibility Assessment, HRSN service delivery, service follow-up). Members will be eligible for their annual Screening 12 months after their original Screening date, regardless of any Re-Screens due to a major life event. Major life events may include: • Change in functioning (including an increase or decrease of symptoms or a new diagnosis); • Inpatient or outpatient hospital admittance and/or discharge; • Serious injury; • Admittance, discharge, or transfer from detox or residential placement; • Significant change in housing, including move to a different SCN region, move to different housing, or loss of housing; • Significant change in income or support resources; • Significant change to family, including but not limited to: marriage or divorce; giving birth (regardless of outcome) to or adopting a child, loss of a family member; • Arrest; • Loss of benefits; or • Change in coverage from FFS to Managed Care

Reimbursement for Screening: To receive reimbursement through the SCN program, Screening must:

- *Be conducted on behalf of a Medicaid member:* While Screenings of individuals beyond Medicaid members may be sent to the SHIN-NY, only Screenings of eligible Medicaid members (both FFS and Managed Care members) will receive reimbursement

- *Use the standardized tool:* Screenings must use the AHC HRSN Screening Tool or another Screening instrument with identical wording and LOINC coding as the AHC HRSN Screening Tool for question-and-answer pairs. Refer to section e. Data sets, Terminologies and Coding for technical Screening requirements. Questions cannot be adjusted or changed. SCNs should reach out to OHIP Contract Managers to speak with NYHER data subject matter experts before conducting any proposed mappings to the LOINC coding in the AHC HRSN Screening Tool

- *Answer key Screening questions:* In order for a Screening to be reimbursed, question 0 (consent) must be answered, and 1 additional question within #1-12 must have a response corresponding to a valid LOINC code which cannot be a Data Absent Reason code. This applies to screens completed within the SCN IT platform or outside of the SCN IT Platform. Refer to section e. Data sets, Terminologies and Coding for Data Absent Reason coding requirements.

- *Be entered into the SCN IT Platform or a Platform that can share data with the SCN IT platform:* While Screening by organizations that are not contracted as part of the SCN is encouraged, organizations must be contracted with the SCN Lead Entity in order to receive reimbursement. Screeners contracted with the SCN Lead Entity can either use the SCN IT Platform or an off-platform screening tool capable of sharing data with the SCN IT platform or QE
    - **Screenings conducted within the SCN IT Platform:** Screening can be conducted by employees of the SCN Lead Entity or by contracted organizations in the Network. Screening conducted within the Network will receive reimbursement (assuming criteria outlined in Reimbursement for Screening Section below are met). Refer to section e. Data sets, Terminologies and Coding for SCN IT Platform technical Screening requirements.
        - Wherever possible, OHIP encourages SCN Social Care Navigators to conduct both Screening and Eligibility Assessment in the same encounter to streamline member experience and allow faster access to services.
    - **Screenings conducted outside the SCN IT Platform:** Contracted organizations using off-platform screening tools are encouraged to conduct Screenings and send the results to SHIN-NY via a QE. These Screens can then be shared with and acted on by the SCNs. Screenings conducted by organizations that are not contracted with the SCN Lead Entity will not be reimbursed, but SCN IT Platforms must be able to accept any/all Screenings routed for their members. Refer to section e. Data sets, Terminologies and Coding as well as "Data Specification for Providers Submitting Screenings via CSV or CCDA" linked on the NYeC website under "Data Specifications for Providers – View Data Specifications" for technical requirements of Screenings conducted outside the SCN IT Platform.
        - OHIP encourages organizations conducting Screening to contract with their regional SCN Lead Entity in order to receive reimbursement
        - SCN Social Care Navigators are expected to conduct Social Care Navigation for members who have an identified unmet HRSN in a timely manner *(see HRSN Network Capacity and Access)*

- *Be the member's annual Screen or a verified Re-Screen due to a major life event:* SCNs will only be reimbursed for one Screen per year (rolling 12 months), or for a Re-Screen due to a major life event. Major life events can warrant paid Re-Screening and can be tracked using the Re-Screening HCPCS code and

supporting modifier to indicate it is a valid Re-Screening. If a Medicaid Managed Care member undergoes an Eligibility Assessment following the Screening, the Social Care Navigator should document the life event in the Medicaid Managed Care member's Social Care Plan (*see Table 5-1 for list of major life events*). Members can receive up to 1 reimbursed Re-Screen per year following their initial Annual Screening.

- *Involve 1:1 member interaction:* Screening must include a 1:1 interaction between the screener and member for the screener to be eligible to receive payment. If a member independently completes Screening (e.g., via a paper form) and thereafter discusses the results with a provider, the provider may be reimbursed for the time spent engaging with the member on the Screening. Providers will not receive payment if a member self-screens without a subsequent 1:1 interaction with a provider, including Screenings in which the member only uses an online Self-Screening tool or other digital Screening with no 1:1 human interaction (e.g., online form, AI chatbot)
    - Screening reimbursement is time based and includes the time spent explaining the SCN program to a member, obtaining consent, walking through the Screening, inputting the member's information and answers to Screening questions, and responding to the member's questions about next steps. If a Screening takes fewer than 8 minutes, it will not be reimbursed. If a Screening takes 8 minutes or more, it may be reimbursed.
    - If a Self-Screening is not accurate (e.g., expired CIN, incorrect date of birth, inaccurate responses) and requires SCN to reach out to the member to validate member identity and re-enter member Screening answers into the IT Platform, the 1:1 interaction with a member to update the Screening may be reimbursed.

Geographic location of Screening: Members can be screened anywhere in the state, regardless of their assigned SCN region and SCNs are encouraged to contract with each other to facilitate reimbursement for Screening as needed. If a member presents to a SCN that is not their current SCN (based on current address registered with Medicaid, as reflected in MEVS), the SCN may screen the member or refer them to the currently assigned SCN. The member's currently assigned SCN should reimburse the SCN that conducted the Screening if contracted with the SCN Lead Entity. If the member is screened outside of the currently assigned SCN region, the Screening will be a part of the daily Screening extract (flat file) or real-time FHIR API that goes via the SHIN-NY to the currently assigned SCN, not to the SCN that conducted the Screening (*see Member relocation and change of address for more details*).

The current SCN (based on current Medicaid member address registered with LDSS or NYSOH) must hold a record of the member's Screenings in the IT Platform either by obtaining it from the SHIN-NY or re-screening the member (moving regions is considered a major life event and therefore a valid reason for a Re-screening).

Checking for duplication of Screening: When Screening is conducted by Social Care Navigators within the SCN, OHIP expects that the Social Care Navigator will confirm that the Screen is not duplicative of an existing Screen on file for the member.

SCNs will incorporate Screenings from a daily extract or real-time FHIR API from the SHIN-NY into the SCN IT Platform that Social Care Navigators will be able to query to determine Screening status and monitor for duplication. Social Care Navigators must have the ability to query the member data from the SCN IT Platform.

The process to check for duplication of Screenings is similar to that used by ecosystem partners to submit Screening for Social Drivers of Health measure as a reported Clinical Quality Measure (CQM). To prevent

duplication of HRSN Screening efforts, SCN Lead Entities will need to provide training and education to Social Care Navigators in their contracted Network for steps to query SCN IT Platform to confirm if a Screening was already completed within the past year.

Screening of children and youth: OHIP's vision is for New York State to be a healthy community of thriving individuals and families. To advance that vision, OHIP is deeply committed to SCNs strengthening the physical, mental, and social well-being of New York's children and youth. Children and youth participating in New York's SCN program will experience a similar member journey to adult participants: they should be screened for unmet HRSNs, connected with appropriate HRSN services, receive services and Social Care Planning, and receive follow-up to determine whether their HRSNs have been addressed and if ongoing services are needed.

However, there are a few details of the SCN program that will be somewhat different for children and youth, particularly around Screening, assessment for SCN eligibility, and Social Care Planning. The primary aspects of the program that are distinct for children and youth can be found in sections Screening (this section), Eligibility Assessment, and Social Care Plans.

- *Expectations for Screening minors:* As with adult Medicaid members, SCNs are responsible for Screening all children and youth enrolled in Medicaid for unmet HRSNs using the same standardized AHC HRSN Screening tool. Screening should be done for each individual Medicaid member. SCNs are encouraged, but not required, to screen parents and caregivers and other children in the household enrolled in Medicaid at the same time as the children and youth they are screening.
- *Role of the child vs. the parent, guardian, or legally authorized representative when screening children:*
    - **For children under 10 years old:** The parent, guardian, or legally authorized representative will respond to the Screening questions on the child's behalf, and the parent, guardian, or legally authorized representative can consent to have the child's Screening information shared.
    - **For children ages 10 and older:** The parent, guardian, or legally authorized representative will typically respond to the Screening questions on the child's behalf, but the child can agree to be screened and answer Screening questions on their own when necessary and the child is developmentally able to understand (e.g., when adolescents present on their own for confidential health care services). The child can consent to sharing Screening information.
    - **Parent and Guardian:** At the discretion of the SCN Lead Entity, Social Care Navigators may request for a parent or guardian to identify themselves.
    - **Legally Authorized Representative**: At the discretion of the SCN Lead Entity, Social Care Navigators may request documentation (court issued, etc.) from anyone presenting as a legally authorized representative. The Social Care Navigator will save this documentation in the Social Care Plan.
- *Guidance for minors living independently or children in foster care:* Minors living independently of parents or that are parents, pregnant, and/or married, and who are otherwise capable of completing the Screening on their own behalf can do so. Children in Voluntary Foster Care Agencies (VFCAs) may be screened by the Foster Care Agency and have the guardian or parent complete the Screening on the minor's behalf.
- *Training requirements to screen children and youth:*
    - OHIP does not require a child-specific training for HRSN Screeners. However, all Screeners are expected to complete the list of trainings suggested in the Training Expectations section, including trauma-informed training

- SCN organizations working with children and youth are expected to understand their legal obligations relating to minors. SCNs are encouraged to use and leverage external resources as they are available (e.g., NYCLU Guide to Minors' Rights in NYS) to understand the rights of children and minors and operate within legal requirements

- *Screening documentation for children:* As for adults, all Screening responses are required to be entered into the SCN IT Platform (either directly or through a platform capable of sharing data with the SCN IT platform). Platforms are not required to capture a data element for the name / relationship of the person who completed the Screening on a child's behalf. However, SCNs are expected to include this in the Social Care Plan
- *Flexibility to tailor Screening processes for children:* When conducting Screening for children and youth, SCNs are encouraged to consider tailoring their Screening processes where appropriate, such as where the Screening takes place and how questions are explained

v. AHC HRSN Screening Tool

Members will be screened using the required AHC HRSN Screening Tool to assess needs across a range of HRSN domains. These Screenings will contain questions related to six HRSN domains: housing and utilities, nutrition, transportation, employment, education, and interpersonal safety. Screenings will help identify unmet HRSNs and tailor services to address those needs.

A sample of the tool is shared below and made available by CMS.

The AHC HRSN Screening Tool is distinct from the UAS Uniform Assessment System (UAS) Community Health Assessment, and SCN Screening efforts are separate from the UAS requirements.

Screeners will use the AHC HRSN Screening Tool or a comparable assessment instrument with identical LOINC coding as the AHC Tool for question-and-answer pairs and must be approved by OHIP. It must also contain "Question 0" to obtain necessary consent. Questions cannot be adjusted or changed.

SCNs should reach out to OHIP Contract Managers to speak with NYHER data subject matter experts before conducting any proposed mappings to the LOINC coding in the AHC Tool.

Each answer to Screening questions has a corresponding LOINC code that is used to determine if the Screening is positive *(for an overview of these LOINC Codes, see Screening for Social Risks: LOINC Codes).* The following table outlines permitted response option to each Screening question.

Table 5-2: AHC HRSN Screening Tool

Housing and Utilities	
1. What is your living situation today?	• *I have a steady place to live* • *I have a place to live today, but I am worried about losing it in the future* • *I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)*

2. Think about the place you live. Do you have problems with any of the following? Choose all that apply.	• *Pests such as bugs, ants, or mice* • *Mold* • *Lead paint or pipes* • *Lack of heat* • *Oven or stove not working* • *Smoke detectors missing or not working* • *Water leaks* • *None of the above*
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	• *Yes* • *No* • *Already shut off*
Food Security	
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	• *Often true* • *Sometimes true* • *Never true*
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	• *Often true* • *Sometimes true* • *Never true*
Transportation	
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	• *Yes* • *No*
Employment	
7. Do you want help finding or keeping work or a job?	• *Yes, help finding work* • *Yes, help keeping work* • *I do not need or want help*
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	• *Yes* • *No*
Interpersonal Safety	
A total score of 11 or more of the number values for answers to the questions below indicates that the person might not be safe.	

9. How often does anyone, including family and friends, physically hurt you?	• *Never (1)* • *Rarely (2)* • *Sometimes (3)* • *Fairly often (4)* • *Frequently (5)* • *Asked but declined* • *Not asked*
10. How often does anyone, including family and friends, insult or talk down to you?	• *Never (1)* • *Rarely (2)* • *Sometimes (3)* • *Fairly often (4)* • *Frequently (5)* • *Asked but declined* • *Not asked*
11. How often does anyone, including family and friends, threaten you with harm?	• *Never (1)* • *Rarely (2)* • *Sometimes (3)* • *Fairly often (4)* • *Frequently (5)* • *Asked but declined* • *Not asked*
12. How often does anyone, including family and friends, scream or curse at you?	• *Never (1)* • *Rarely (2)* • *Sometimes (3)* • *Fairly often (4)* • *Frequently (5)* • *Asked but declined* • *Not asked*

AHC Screening Questions #1-8: In line with the established AHC HRSN Screening tool and in order to ensure high quality Screening data, "Asked but declined" and "Not asked" should NOT be included as response options for questions #1-8.

AHC Screening Questions #9-12: Given the sensitive nature of questions #9-12 (Interpersonal Safety), they may not always be asked and members may not always answer. "Asked but declined" and "Not asked" are permitted responses. They should be available in the IT platform and Screeners may use them as appropriate.

If needed, Screeners can still proceed through the Screening even if they need to leave any of questions #1-12 blank with an appropriate Data Absent Reason code. Refer to section e. Data sets, Terminologies, and Coding for Data Absent Reason coding requirements. These Screenings should still be actioned if an unmet need is indicated for other Screening questions (i.e., initiating Eligibility Assessment for identified unmet need).

vi. Considerations for interpersonal safety questions asked during Screening

Creating a safe and appropriate environment for Screening: The interpersonal safety (IPS) questions should only be asked in a safe and appropriate environment. Based on their training, Social Care Navigators should determine when it is appropriate not to ask these questions (for example, if a partner or family member is with the member while they are being screened).

Providing support to members: While a member may receive an interpersonal safety score below the threshold needed to identify the member as having an unmet HRSN regarding safety (e.g., due to member not answering all 4 interpersonal safety questions), the member may still benefit from support related to interpersonal safety. When appropriate, Social Care Navigators can offer ~~may consider~~ navigating a member to existing local, state, or federal resources for interpersonal safety support, even if their safety score is not above the threshold. If a member has interpersonal safety concerns as confirmed during the eligibility assessment and wants assistance, the Social Care Navigator must prioritize issuing the referral to existing local, state or federal services as close to same day of the eligibility assessment as possible.

It is OHIP's goal that SCN Lead Entities establish HRSN Screening processes that appropriately support and ensure the safety of children and youth. OHIP expects that SCN Lead Entities will ensure Social Care Navigators undertake appropriate training so they can support members and address member needs, including those related to IPS. In addition to requiring Social Care Navigators to take the NYS Mandated Reporter training, OHIP encourages SCN Lead Entities to share guidance with Social Care Navigators and HRSN service providers in their Network on working effectively with children and youth.

Screeners and Social Care Navigators should familiarize themselves with resources available for members in their community. Many communities have emergency personnel, including advocates and law enforcement, who are specially trained to respond to interpersonal violence crises. The NYS Office for the Prevention of Domestic Violence provides many resources including, but not limited to, a 24/7 hotline (1-800-942-6906), text line (1-844-997-2121), and web chat for confidential support.

IPS questions and eligibility for services: Answers to IPS questions asked during the HRSN Screening do not impact a member's eligibility to receive services. Following the member's Screening, a Social Care Navigator will assess a member's eligibility to receive Enhanced HRSN Services during the Eligibility Assessment. Refer to Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service for guidance on how to verify the criteria of "a health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect." Answers to IPS questions in the HRSN Screening do not verify this eligibility criteria.

c. SOCIAL CARE NAVIGATION

i. Social Care Navigators

Systematically addressing the HRSNs of Medicaid members requires that Screening be the beginning of a process through which the right HRSN services are identified, the member is connected with HRSN service providers in their community, and there is follow up to ensure services were delivered and the member's needs have been addressed.

Social Care Navigators are essential to enabling that end-to-end process, delivering a seamless experience to members from Screening to delivery of services. They are accountable for ensuring that members get the HRSN services they need in way that is accessible and appropriately tailored to each member's needs. Members can also use the SCN's Social Care Navigators as their direct point of contact for ongoing HRSNs.

Social Care Navigators may be employed by the SCN Lead Entity or by other entities in the Network (such as HRSN service providers and health care providers) or MCOs. For example, care managers or resource coordinators employed by MCOs, health care providers, or care management providers may play Social Care Navigator roles as long as they are contracted by the SCN Lead Entity to perform the role and are trained to use the SCN IT Platform. While MCOs may play Social Care Navigator roles to screen, navigate, and refer members, they will not receive payment for doing so.

Although New York State does not require it, OHIP envisions that Social Care Navigators will be Community Health Workers. Social Care Navigators serve as trusted community members who have the ability to broadly support health and well-being.

ii. Reimbursement for Social Care Navigation

Social Care Navigation will be reimbursed via payment based on the HRSN fee schedule for care management (for 15-minute increments). Attempts by a Social Care Navigator to contact a member (e.g., if a member cannot be reached after a Screening that identifies an unmet HRSN) will not be reimbursed. Social Care Navigation must be conducted using the SCN IT Platform to be eligible for reimbursement.

In order to receive reimbursement through the SCN Program, Navigation must:

- *Be conducted on behalf of a Medicaid member:* Only Navigation of enrolled Medicaid members (both FFS and Managed Care members) will receive reimbursement. See Covered HRSN Service, Section 1. Care Management part 1.1 Navigation Services (Eligibility Assessment and Navigation) for FFS and non-eligible Medicaid Managed Care members and part 1.2a Enhanced HRSN Care Management (Eligibility Assessment) for eligible Medicaid Managed Care members
- *Be conducted by a Social Care Navigator:* Service must be delivered by Social Care Navigator; Social Care Navigators may include employees of the SCN Lead Entity or of organizations that are contracted as part of the Network. Navigation will not be reimbursed if conducted through an automated program or website
- *Be time spent engaging with the member or on behalf of the member:* Social Care Navigators will only be reimbursed for time spent with a live person (on the phone, in person, virtual) engaging with a member or other stakeholders (e.g., parent, guardian, legally authorized representative, clinical provider) on behalf of the member with regards to eligibility or care coordination
- *Be conducted using the SCN IT Platform or system that is able to send referral information to the SCN IT Platform:* The Social Care Navigator must send the referral information either through the SCN IT platform or through an integrated or interoperable application that is able to incorporate referral information into the SCN IT platform. For example, if a provider has a different IT system from the SCN but has an EHR module from that system and is able to send referral data to the SCN's platform or the SCN platform is able to receive data via FHIR integration, Navigation can be reimbursed
- *Be documented in the Social Care Plan*: Details of Navigation to Enhanced HRSN Services, including any questions asked during the assessment, must be documented in the member's Social Care Plan

iii. Navigation Process

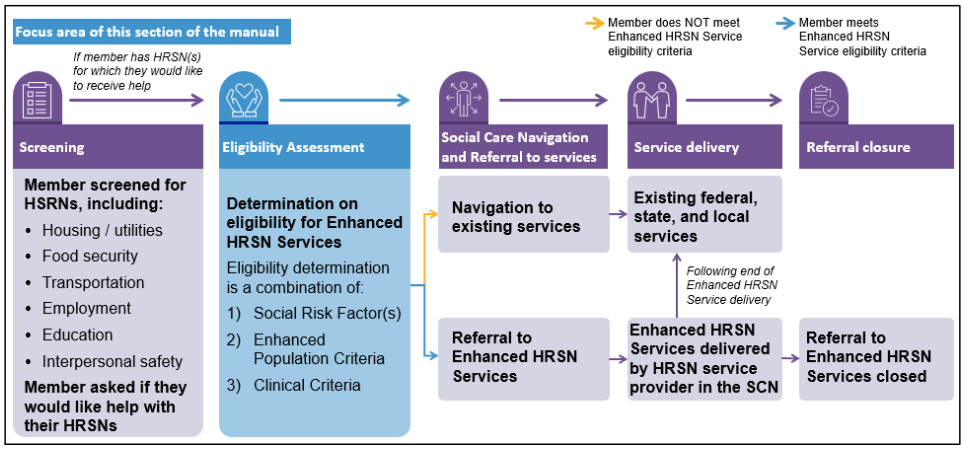
The Navigation process includes validating member eligibility for Enhanced HRSN Services, managing Closed Loop Referrals for HRSN Services, and developing Social Care Plans for eligible Medicaid Managed Care members.

Eligibility Assessment. This includes Social Care Navigators working with the member to confirm their unmet HRSNs by selecting granular ICD-10 and SNOMED-CT descriptions; understanding the current services a member may already be receiving; and discussing additional Social Risk Factors and clinical criteria to understand which HRSN Enhanced Services a member may be eligible for. This assessment will be based on information provided in the Enhanced Services Member File shared by the MCO and additional information provided by the member and/or their health care provider.

Navigation to existing federal, state, or local services or referral to HRSN services. Depending on the outcome of their Eligibility Assessment, members may be referred to HRSN Enhanced services, or to existing state, federal, and local benefit programs. Navigation to existing services includes connection to Medicaid clinical care management programs, such as Health Homes. The Enhanced Population will be navigated under HRSN Care Management. Social Care Navigators are responsible for changing statuses to "Completed" after a member accepts navigation to local, state, or federal services.

Social Care Plans. Social Care Navigators will be responsible for developing Social Care Plans for eligible members that include a summary of member needs, eligibility, and services to which members are referred.

d. ELIGIBILITY ASSESSMENT



i. Medicaid Member Eligibility

New York State has worked with CMS to determine which HRSN services can be reimbursed for specific populations through NYHER. Medicaid members whose Screenings demonstrate unmet HRSNs should receive an Eligibility Assessment to determine eligibility for Enhanced HRSN Services.

Eligible Medicaid Managed Care members who meet certain criteria (determined by the Eligibility Assessment) may receive Enhanced HRSN Services. Other Medicaid members may be directed to existing federal, state, and local programs, including members who are also receiving Enhanced HRSN Services, when applicable. A member's eligibility for Enhanced HRSN Services does not impact or change general Medicaid eligibility in New York State or their enrollment with their MCO.

Certain populations are excluded from receiving Screening, Navigation, and Enhanced HRSN Services that are reimbursed through NYHER. NYHER cannot fund Screening, Navigation, or Enhanced HRSN Services for the following populations listed in Table 5-3. Members in these excluded populations have been identified and excluded upstream of the SCNs in the Medicaid Eligibility File (MEF) by OHIP and the Enhanced Services Member File (ESMF) by MCOs. Members who move from an eligible population to an excluded population can be identified in the Disenrollment Change Report (DCR) with "HRSN" as the reason they dropped off the MEF. For more detailed information and examples for determining member eligibility and utilizing the MEF, ESMF, DCR, and MEVS, please refer to the Data and Systems Implementation Guidance (DSIG).

Table 5-3: Excluded Populations

Population excluded from NYHER	Population Exclusion Reason
Members with provisional eligibility for Medicaid benefits	No coverage; unable to enroll in Managed Care
Members who are eligible for emergency services only	Limited services; unable to enroll in Managed Care
Members participating in the Medicare Savings Program	Unable to enroll in Managed Care
Members exclusively in the Family Planning Benefit Programs	Population is not eligible for Federal Funding Match
Members residing in a state psychiatric facility	Limited services; institutional setting; unable to enroll in Managed Care
Members who are currently incarcerated	Limited services; institutional setting; unable to enroll in Managed Care
Members who are in a NYC Public Shelter (members with Aid Category Code 40 only)	Population is not eligible for Federal Funding Match
Aliessa Court Ordered Individuals/ Qualified Aliens not eligible for federal financial participation	Population is not eligible for Federal Funding Match
Members who are non-citizen aged 65+ years old	Population is not eligible for Federal Funding Match

Population excluded from NYHER	Population Exclusion Reason
Members who have Alien Eligibility	Population is not eligible for Federal Funding Match
Members enrolled as Legal Aliens	Population is not eligible for Federal Funding Match
Members who are undocumented pregnant women	Population is not eligible for Federal Funding Match
Individuals enrolled in Child Health Plus	Population is not part of the Medicaid Program
Individuals enrolled in Essential Plan	Population is not part of the Medicaid Program
PACE	Plan type unable to receive non-risk adjusted payments; HRSN PMPM is non-risk adjusted
FIDA IDD	Plan type unable to receive non-risk adjusted payments; HRSN PMPM is non-risk adjusted
Individuals with a "county of fiscal responsibility" code of 97, except for individuals in the New York Office of Mental Health family care program who other than their residence in district 97 would be eligible to enroll in MMMC	Population is not eligible for Federal Funding Match; excluded from 1115 demonstration populations per STCs
Individuals with a "county of fiscal responsibility" code of 98 including Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center	Population is not eligible for Federal Funding Match; excluded from 1115 demonstration populations per STCs
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage (Individuals with a "county of responsibility" code of 99)	Population is not eligible for Federal Funding Match; excluded from 1115 demonstration populations per STCs
Members permanently placed in a nursing home	Programmatic decision to exclude because they are permanently placed in an institutional setting
Members enrolled as Qualified Alien/PRUCOL	Population is not eligible for Federal Funding Match
Members enrolled as Qualified Alien Not MOE (Maintenance of Effort) Eligible	Population is not eligible for Federal Funding Match
Special Agricultural Workers (SAW)	Population is not eligible for Federal Funding Match

Population excluded from NYHER	Population Exclusion Reason
Individuals with access to comprehensive private health insurance, with the exception of IB Duals, MAP, and MLTCP lines of business	Unable to enroll in Managed Care
Members enrolled under Supplemental Payment – OTB Retiree NYS Medicaid NYC	Population is not eligible for Federal Funding Match

Coding information identifying the excluded populations is available in the ESMF guidance on the NYHER Systems Workgroup SharePoint. ESMF guidance contains data elements and values that are not available to the SCN LEs in the MEVS or ePACES response.

Eligible populations:

- **Medicaid FFS:** Most Medicaid FFS populations are eligible for reimbursed Screening and Navigation to existing federal, state, and local services (*see Table 5-3 for excluded populations*).
- **Medicaid Managed Care:**
  - *Some Medicaid Managed Care members are eligible for Enhanced HRSN Services through the SCN*: If a member is enrolled in Medicaid Managed Care and meets one of the criteria from Table 5-5 below as determined during an Eligibility Assessment and has an unmet HRSN as indicated by the AHC HRSN Screening Tool, they are eligible for Enhanced HRSN Services. SCNs will notify the member during the Eligibility Assessment of the services for which they are eligible. Eligible lines of business for Enhanced HRSN Services are:
    - **Mainstream Medicaid Managed Care (MMMC)**
    - **HIV Special Needs Plans (HIV-SNPS)**
    - **Health and Recovery Plans (HARP)**
  - *Some Medicaid Managed Care lines of business are eligible for some, but not all, Enhanced HRSN services:*
  - **Managed long-term care (MLTCP) and Medicaid Advantage Plus (MAP):** MLTCP and MAP members are NOT eligible for Nutrition services with the exception of Cooking Supplies. Social Care Navigators must still contact the MLTCP and MAP plan if the member has other unmet nutrition needs (i.e., needs meal assistance).
  - MLTCP and MAP members may be eligible to receive other Enhanced HRSN Services. For some Housing services (2.1 Home Accessibility and Safety Modifications, 2.2 Home Remediation, 2.3 Asthma Remediation, 2.8 CTS, and 2.10 Housing Transition and Navigation Services), Social Care Navigators should accept a member's verbal attestation of services received by their MLTCP and MAP plan and document in the Social Care Plan.
  - *Some Medicaid Managed Care members are eligible for Navigation only:* Medicaid Managed Care members who do not meet population criteria in Table 5-4 but who still have unmet HRSNs may receive Navigation to existing federal, state, and local services. If a member has Medicaid Managed Care, the Social Care Navigator can provide hands-on support and assist with the application for WIC, SNAP, TANF or other existing programs / services.

Medicaid Managed Care members who are eligible for Enhanced HRSN Services may choose not to receive Enhanced HRSN Services and can be navigated to existing federal, state, and local services.

Table 5-4: Navigation and Enhanced HRSN Services Eligibility

Navigation Services	**Medicaid FFS members** and **Medicaid Managed Care members (excluding populations in Table 5-3)** may receive Navigation to existing federal, state, and local services to address HRSNs.
Enhanced HRSN Services	**Medicaid Managed Care members** who meet one or more of the following criteria for an Enhanced Population (as defined in Table 5-13) and have an identified unmet HRSN may receive Enhanced HRSN Services. Enhanced HRSN Services criteria (additional details follow in HRSN Services Section): *i.* *Medicaid High Utilizer* *ii.* *Individuals enrolled in a NYS-designated Health Home* *iii.* *Individuals with Substance Use Disorder (SUD)* *iv.* *Individuals with Serious Mental Illness (SMI)* *v.* *Individuals with an Intellectual and Developmental Disability (I/DD)* *vi.* *Pregnant and postpartum persons* *vii.* *Individuals who are up to 90 days post-release from incarceration with a chronic condition*, including SUD and chronic Hepatitis-c *viii.* *High-risk children under the age of 18*

Eligibility timeframe: Enhanced HRSN Services will be delivered by the SCN for a pre-determined duration period. Most Enhanced HRSN Services will be delivered for up to 6 months and may be used in increments. Selected services may be renewed for an additional 6 months (3.2a Medically Tailored Meals; 3.2b Clinically Appropriate Home Delivered Meals; 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions; 3.4 Fresh Produce and Non-Perishable Groceries). Other services may be renewed in 6-month increments up to the duration of the waiver (2.10 Housing Transition and Navigation Services; 3.1 Nutrition Counseling and Education; 4.1 Transportation). Additional details are available in the fee schedule. Some members may be eligible to receive services for longer periods (e.g., pregnant individuals may receive Nutrition services for a longer period of time) *(see Covered HRSN Services)*. Social Care Navigators may consider the member's upcoming renewal or prospective disenrollment date in making determinations related to Enhanced HRSN Service delivery. For recurring services (e.g., services that require more than a one-time delivery), the Social Care Navigator MAY (at the discretion of the SCN) refer the member for Enhanced HRSN service delivery only up until the renewal date or prospective disenrollment date, whichever comes first. SCNs will need to establish workflows for Social Care Navigators to re-authorize services as appropriate based on member renewal and reenrollment.

Lookback period to determine eligibility: When a lookback period is needed to determine population eligibility (e.g., Medicaid High Utilizer, etc.), MCOs and SCN Lead Entities will use a 12-month rolling look back period, not the calendar year.

Duration of eligibility: It is important for SCNs to ensure that only eligible Medicaid members receive Enhanced HRSN Services. Members remain eligible to have services, for which they are eligible to receive, initiated for up to 6 months following the Eligibility Assessment. During this 6-month period, members can be referred to services without requiring a new Eligibility Assessment. However, before making a referral, Social Care Navigators must still verify the member's Medicaid ~~enrollment~~ eligibility in MEVS on the day of the referral. If the member has not started services for which they are eligible within 6 months of receiving an Eligibility Assessment, members seeking to start Enhanced HRSN Services must undergo a new Eligibility Assessment.

If members have initiated services within 6 months of their Eligibility Assessment, they do NOT need to receive another Eligibility Assessment at 6 months. Instead, members should exhaust the duration of services for which they were authorized and receive an additional Eligibility Assessment only if services require renewal.

Reassessment of eligibility: If a member is determined to be ineligible for Enhanced HRSN Services, a re-assessment will only be reimbursed after 12 months of their initial Eligibility Assessment, unless they experience a major life event.

Service duration: The 6-month service duration for Enhanced HRSN Services and for 6-month re-authorization is defined as 6 calendar months from the Service Start Date (e.g., service start date of 8/1/25 and service end date of 1/31/26). Service Start Date must be calculated from the 1st date of service provision for the member where applicable (e.g., 6 months of MTM is based on date of 1st meal provision to the member).

Service duration pause: A member may decide to pause their Enhanced HRSN Service provision for various reasons and should communicate planned and unplanned breaks in service to their Social Care Navigator and HRSN service provider. A member's request for a pause in service will not impact the length of their approved service duration.

Member is temporarily in institutional and/or residential facility different than permanent residential address:

- Members may not receive Screening, Navigation, or Enhanced HRSN Services in an institutional or residential facility
- If member will be in an institutional/residential facility for less than 90 days or has a discharge date, then it is considered a temporary relocation. While member is in institutional/residential facility, Enhanced HRSN Services should be paused and can be restarted upon discharge
- If member will be in an institutional/residential facility for more than 90 days and does not have a discharge date, then the SCN should end provision of services; member should be re-screened and re-assessed after discharge

Member's SCN: A Medicaid member's SCN is based on their latest residential address by county (not zip code) assigned by Medicaid. Members must receive services in the SCN covering the county of their current residential address (based on Medicaid data). If a member moves out of one SCN service area and into another, the outgoing SCN will communicate member address updates to the MCOs and work with members to update their address with Local Department of Social Services (LDSS) or New York State of Health (NYSOH). Outgoing SCN will coordinate and hand-off of the member to the new SCN *(see Member relocation section).*

ii. Eligibility Assessment process

Once a member is screened and found to have an unmet HRSN, a Social Care Navigator will obtain member consent to conduct an Eligibility Assessment and verbal attestation that information provided during the Eligibility Assessment is complete and accurate to the best of the member's knowledge.

The Social Care Navigator will then verify the member's identity and Medicaid eligibility within MEVS or ePACES. Social Care Navigators must confirm member's eligibility to receive Navigation reimbursed via NYHER (*see Table 5-3 for excluded populations*) through the MEF, ESMF, and Disenrollment Change Report (DCR). Once confirmed, a Social Care Navigator will assess the member's eligibility to receive Enhanced HRSN Services. For a high-level overview of the steps of this Assessment, see Figure 5-2. A list of standardized questions built in the SCN IT Platform will facilitate the Assessment. If needed, the Social Care Navigator can also ask additional questions to better understand the member's needs.

Figure 5-2: Eligibility Assessment activities

Eligibility Assessment				
Step		**Activity***	**Details**	**Data reference**
	1	**Collect Member consent and attestation to complete and accurate information**	Ask the Member for verbal consent to conduct Eligibility Assessment and verbal attestation that information provided during the Eligibility Assessment is complete and accurate to the best of their knowledge. Document both consent and attestation in the SCN IT Platform.	• Questions built into SCN IT Platform
	2	**Confirm Member identity and Medicaid enrollment**	Check Member Medicaid enrollment via either MEVS or ePACES	• MEVS or EPACES
	3	**Confirm HRSN**	Check the SCN IT Platform for HRSN Screening results and confirm with Member	• AHC HRSN Screening results
	4	**Confirm desire for services**	Inquire if the Member would like to receive services for unmet needs either via existing services or Enhanced HRSN Services	• Member input
	5	**Check Enhanced Population**	Check if Member is part of an Enhanced Population in the Enhanced Services Member File and through alternate verification pathways (e.g., provider attestation, Member documentation)	• Enhanced Services Member File • Member input
	6	**Conduct follow-up questions with Member**	For each unmet HRSN, ask additional follow-up questions, including whether they are receiving existing services	• Questions built into SCN IT Platform
If Member is part of an Enhanced Population, complete steps 7-9.	7	**Confirm eligibility for Enhanced HRSN Services**	Check Member eligibility against Social Risk Factors and clinical criteria for particular Enhanced HRSN Services using Enhanced Services Member File and other relevant verification pathways	• Enhanced Services Member File • Member input
	8	**Confirm desire for services and inform of potential COI**	Inquire if Member would like to receive Enhanced HRSN Services for which they are eligible and inform Member of SCN LE dual role as Navigator & Enhanced HRSN Service provider, if relevant; ensuring Member receives a statement on Freedom of Choice	• Member input
	9	**Create care plan**	Automatically generate a Social Care Plan for Member on the SCN IT Platform based on unmet HRSNs and eligibility criteria gathered	• Questions built into SCN IT Platform

Eligibility Assessment requirements differ by population:

- **For FFS members:** Only steps 1-4 and step 6 are required
- **For MMC members who are part of an Enhanced Population:** Steps 1-9 are required
- **For MMC members who are NOT part of an Enhanced Population:** Only steps 1-6 are required

Eligibility Assessment steps

Step 1. Collect member consent and attestation to complete and accurate information. Member consent must be documented in the SCN IT Platform

- The Social Care Navigator must ask for the member's consent to conduct the Eligibility Assessment using the following language:
  I would like to see, based on your medical history including information Medicaid collects, if you qualify for any services that could be helpful and which would be free to you. Is this okay with you? Do you have any questions?
- The Social Care Navigator must ask for the member's verbal attestation that information provided during the Eligibility Assessment will be complete and accurate to the best of the member's knowledge

Step 2. Confirm the member's identity and their Medicaid enrollment

The Social Care Navigator should match information provided by the member (e.g., name, address, Medicaid ID number) with data in the Medicaid Eligibility Verification System (MEVS) or ePACES to verify the member's identity and their Medicaid enrollment status in FFS or MMC as an eligible population to receive services reimbursed via NYHER. See Table 5-3 for excluded populations. This step is used to confirm that the member is actively enrolled in Medicaid at the time of service. Members in excluded populations, see Table 5-3, have been identified and removed upstream of the SCNs through the Medicaid Eligibility File (MEF) by OHIP and the Enhanced Services Member File (ESMF) by MCOs. Members who transition from an eligible population to an excluded population can be identified in the Disenrollment Change Report (DCR), which will show "HRSN" as the disenrollment reason.

SCN IT Platform vendors are required to have permanent integration with MEVS within the SCN IT Platform. If the Social Care Navigator is unable to access MEVS through SCN IT Platform, then the Social Care Navigator may submit a request for eligibility verification by:

1. Checking ePACES and reviewing the enrollment details OR
2. Calling eMedNY's telephone verification service to confirm enrollment. See additional guidance for ePACES/eMedNY methods here

If Social Care Navigators do not have access to eMedNY or ePACES, SCN LEs may establish a workflow whereby LEs can check these sources and provide information to Social Care Navigators.

If Social Care Navigators are using ePACES or eMedNY's telephone verification services to confirm MMC enrollment, Social Care Navigators should see Table 5-3 above to understand if a member is part of a NYHER-excluded population and therefore is not eligible for Screening, Navigation, or Enhanced HRSN Services.

Situations in which member's address does not match MEVS/ePACES: At the time of Eligibility Assessment, Social Care Navigators should confirm member ID and residential address, collected verbally, before performing Navigation services. If member indicates their address is different from the address listed in MEVS / ePACES, the Social Care Navigator should use the address provided by the member as the primary address for Enhanced HRSN Services.

If a member reports a different residential address *within the same SCN region*: Social Care Navigators should document member's new address in Social Care Plan and initiate the process to update the member's address (*see Member relocation and change of address for more details*).

If member reports a different residential address *in a different SCN region*: Social Care Navigators should initiate the process to update the member's address (*see member relocation and change of address for more details*).

- Social Care Navigator should note member's new address in Social Care Plan and initiate communication with the SCN Lead Entity associated with where the member currently lives, to facilitate a handoff within 5 business days to enable new SCN Lead Entity to navigate the member
- New SCN Lead Entity associated with member's new address will need to wait until member address is updated in NYSOH or LDSS and member appears in MEVS / ePACES, MEF or ESMF to conduct Eligibility Assessment. Member may still be navigated to existing federal, state, and local services in the meantime

Demographic and Physical Disability questions: In most cases, the set of Demographic and Physical Disability questions will have been answered during the member's HRSN Screening. However, if a member did not previously answer the Demographic and Physical Disability questions (either due to skipping or the Screening taking place outside of the SCN IT Platform), they should be answered during the Eligibility Assessment.

The Social Care Navigator should engage with the member to gather their responses on the set of Demographic and Physical Disability questions built into the SCN IT Platform (based on OHIP's Minimum Viable Dataset).

See Screening section above for information on specific questions.

Step 3. Confirm understanding of the member's HRSNs

Check the SCN IT Platform for the member's HRSN Screening results and review any unmet needs with the member. Social Care Navigators will then be required to select the appropriate granular ICD-10 and SNOMED-CT assessment code(s) from a filtered set of code descriptions per the Social Care Coding document that captures the specific unmet need from the member's identified positive response(s) from screening. Entry of this code serves to reinforce the screening answer(s) and constitutes a complete Eligibility Assessment. Identified unmet HRSNs will be automatically mapped to ICD-10 Z codes and SNOMED-CT assessment codes by the SCN IT Platform (*see Eligibility Assessment Coding*).

Situations in which a member's needs identified during the Eligibility Assessment are different than the initial Screening: If a member's unmet HRSNs identified during Screening are different than those identified during the Eligibility Assessment, changes should be made by the Social Care Navigator as follows:

a. If a new unmet need is identified during Eligibility Assessment that was not identified during initial Screening:
   - Initiate a Re-screening for the member or submit a correction to the initial screen
   - **Re-screening Requirements:**
     i. The re-screen is eligible for reimbursement, if there are new screening answers to record and the re-screen is 8 minutes or more.
     ii. Must include all needs addressed during the current Eligibility Assessment. NOTE: If a member was already referred to a service during the original screen and is currently receiving assistance, then the rescreen should not include the need as being "unmet" again.
     iii. The initial Screen and Re-screen must result in a single Eligibility Assessment.
     iv. Correction to Initial Screen Requirements: The screen LOINC answer code and corresponding SNOMED-CT specific to the new unmet need must be noted by the Social

Care Navigator during the Eligibility Assessment and captured in an observation assessment to send through FHIR. Please see the Platform Resource Pack (PRP), for technical guidance specific to the observation assessment on the NYHER Systems Workgroup SharePoint.

b. If an unmet need identified during the initial Screening is found to be incorrect or no longer relevant during the Eligibility Assessment:
    - Capture via a SNOMED change or initiate a re-screening for the member: SNOMED Requirements: The SNOMED CT or ICD 10 code associated with the need identified during the initial Screen must be noted by the Social Care Navigator during the Eligibility Assessment and captured in an observation assessment to send as a FHIR bundle. Additionally, this observation assessment should include the SNOMED of "Not Suspected" representing the condition is no longer suspected (SNOMED value 428263003).

Please see the Platform Resource Pack (PRP), for technical guidance specific to the observation assessment on the NYHER Systems Workgroup SharePoint.

Re-screening Requirements:

i. Must include all needs addressed during the Eligibility Assessment. It must not include the need that is no longer suspected.
ii. The re-screen is eligible for reimbursement, if there are new screening answers to record and the re-screen is 8 minutes or more.
iii. The initial Screen and Re-screen must result in a single Eligibility Assessment.

Step 4. Confirm that the member wants to receive help with unmet HRSNs

Ask if the member would like to receive services for unmet HRSNs. If they do not, end the assessment here.

Step 5. Check whether the member is included in an Enhanced Population

Use information in the Enhanced Services Member File (*see Enhanced Services Member File*) and from interacting with the member to determine whether the member is part of an Enhanced Population for the SCN program, meaning that they may be eligible to receive certain Enhanced HRSN Services.

As part of this process, the Social Care Navigator should ensure that the member they are assessing matches the member listed in the Enhanced Services Member File using the "Member Identifier" fields. The Social Care Navigator must also inform the member that information shared during the Eligibility Assessment could be shared with the member's MCO and with providers.

There are instances in which the information from the interaction between the Social Care Navigator and the member *supersedes* information found in the Enhanced Services Member File (e.g., if relevant criteria are those to which providers and/or members may attest). For more information see *Criteria documentation and attestation*.

In the event the Social Care Navigator learns of information not included in the ESMF, the Social Care Navigator should document any relevant additional information about the member in the SCN IT Platform and share with the MCO through a process determined jointly by the MCO and SCN. If a member states they do not have, or do not want to disclose, a specific clinical condition that the Enhanced Services Member File indicates the member has, the Social Care Navigator will honor the member's statement. The Social Care Navigator should not request that the MCO remove information from the Member File. Members always have the option to decline services.

Social Care Navigators should take the following steps to confirm if a member is included in an Enhanced Population (also applicable for determining clinical criteria and Social Risk Factors for member eligibility for Enhanced HRSN services):

- Social Care Navigators should first check the ESMF
  a. **If criteria has "Y" in ESMF**, then member is either considered part of an Enhanced Population or meets clinical criteria and does not need to be asked to further verify "Y" indications
  b. **If criteria has "N" or "U" in ESMF**, there may not be enough information from the MCO to determine if the member has criteria on file – Social Care Navigators should proceed to follow additional steps for verification *(see below)*
- For values of "N", the Social Care Navigator can view the field "MBR_CONT_PLAN_ENROLL_DT" from the ESMF to inform their next steps with the member. Social Care Navigators should determine which "U" or "N" value could be relevant to ask the member based on the unmet need(s) identified during Screening. Social Care Navigators may reference Table 5-5 to determine which criteria should be discussed with the member
  a. **If EPop_Other field is "N" or "U" and I/DD criteria is relevant for the Eligibility Assessment, Social Care Navigator should reference OPWDD Waiver service duplication field in ESMF data if available.** If the ESMF indicates the member may belong to the I/DD population but is not enrolled in the OPWDD Waiver, the Social Care Navigator should continue to assess the member for potential services provided through the SCN and may provide information about OPWDD eligibility for interested and potentially eligible members
  b. **If Health Homes field is a "U" or "N" in the ESMF**, and field is relevant for the Eligibility Assessment, Social Care Navigators can confirm by using the following methods:
     - Use ePACES to determine Health Home enrollment (if ePACES is accessible). In ePACES/MEVS, Health Home members are tagged with exception code A2 and may also have the Health Home name and assigned care manager following the A2 code AND
     - Directly contact the Health Home's care manager or equivalent to obtain confirmation (verbal, digital, written) of a member's enrollment and, if necessary, request supporting documentation (i.e., screen shot of enrollment confirmation).
- If the member indicates that any relevant criteria with a "U" or "N" apply to the member, the Social Care Navigator should refer to verification pathways outlined in Table 5-16. The Social Care Navigator should then proceed with provider or member attestation pathways as applicable

Table 5-5: Mapping of HRSN domain to relevant ESMF sections

HRSN Domain	ESMF section	Field name	Values to discuss
Nutrition	3: Enhanced Population	All fields	N, U

HRSN Domain	ESMF section	Field name	Values to discuss
	4: Clinical Criteria	Chronic_Condition	N, U
	5: Service Duplication	MTM_ILOS, Nutrition_Counsel, NHTD_Waiver	N, U
Housing	2: Plan Information	Mbr_LOB_Desc	MAP, MLTCP
	3: Enhanced Population	All fields	N, U
	4: Clinical Criteria	All fields	N, U
	5: Service Duplication	Healthy_Homes, OPWDD_Waiver, Childrens_Waiver, NHTD_Waiver, TBI_Waiver	N, U
Transportation	3: Enhanced Population	All fields	N, U
	5: Service Duplication	OPWDD_Waiver, TBI_Waiver, NHTD_Waiver, Childrens_Waiver	N, U
Care Management	3: Enhanced Population	All fields	N, U
	5: Service Duplication	OPWDD_Waiver, TBI_Waiver, NHTD_Waiver, Childrens_Waiver	N, U

Step 6. Ask member follow-up questions within the Eligibility Assessment to better understand their unmet HRSNs

Follow-up questions must be built into SCN IT Platform's Eligibility Assessment. The member's corresponding answers must be documented in the member's Social Care Plan or in the member's profile. The questions are intended for the Social Care Navigator and HRSN service providers that receive referrals to better understand the nature of the member's HRSNs and which services are most appropriate.

Through these questions, the Social Care Navigator will first identify if there is an opportunity to enroll the member in federally funded benefits for relevant services such as SNAP, WIC, or TANF, then select the relevant granular ICD-10 and SNOMED-CT descriptions of the member's unmet needs, and lastly navigate the member using the appropriate "Completed" status. If the member is currently receiving federal benefits, the Social Care Navigator should identify what additional services are being provided to the member to avoid any potential duplication of services.

For MMC members in an Enhanced Population, the following questions are required to be asked of members based on HRSNs. All relevant questions should be answered with Yes / No as part of a comprehensive Eligibility

Assessment. The Social Care Navigator should only ask general questions and questions related to the member's unmet HRSN domain(s). It is acceptable if the member declines or does not know the answer to these questions within the Eligibility Assessment.

General

1. Is the member enrolled in TANF (OTDA)? If the member is enrolled in Managed Care and eligible for TANF, the Social Care Navigator can assist with a TANF application*. The Social Care Navigator must select the appropriate ICD-10/ SNOMED-CT description and "Completed" status for navigation.*
2. What is the member's current employment status?
3. Does the member have income from any source?
4. How many people are in the member's household?

Housing – only required if member has an unmet housing need

1. What type of housing assistance does the member need?
2. Is their household currently working with a housing provider?
3. Is the member on any housing waitlists (i.e., HUD. Section 8, local housing authority, or other voucher programs) or receive a rental subsidy?

Nutrition – only required if member has an unmet nutrition need

1. Is the member enrolled in SNAP (OTDA) and WIC? *If the member is enrolled in Managed Care and eligible for SNAP or WIC, the Social Care Navigator can assist with an application*. *The Social Care Navigator must use the appropriate ICD-10/SNOMED-CT descriptions and "Completed" status for navigation.*
2. Is the member receiving any home-delivered meals or food services?
3. Is the member currently receiving nutritional counseling or education?
4. How many people in the member's household need food assistance?
5. Does the member have the ability to store food, such as a refrigerator?
6. Does the member have cooking supplies such as pots, pans, utensils, plates, etc.?
7. Does the member have any dietary restrictions or food allergies?

For MMC members in an Enhanced Population, required questions for Nutrition Enhanced HRSN Services: When navigating members to Enhanced HRSN Services, Social Care Navigators should determine the type of Nutrition services that are appropriate for each member based on their unique needs and eligibility criteria.

During the Eligibility Assessment, for members who are eligible for BOTH prepared meals (3.2a Medically Tailored Meals) or 3.2b Clinically Appropriate Home Delivered Meals) and groceries (3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions or 3.4 Fresh Produce and Non-Perishable Groceries), Social Care Navigators are required to ask members the following questions to determine the most appropriate service for the member.

1. **Can you prepare and serve adequate meals either by yourself or with the help of a caregiver?**
   - If member answers "No" – Refer to MTM or Clinically appropriate meals (based on eligibility criteria)
   - If member answers "Yes" – Continue to question 2

2. **Would you or a caregiver be able to prepare and serve adequate, nutritious meals if supplied with ingredients and instructions?**
    - If member answers "No" – Refer to MTM or Clinically appropriate meals (based on eligibility criteria)
    - If member answers "Yes" – Refer to food prescription, food vouchers, or pantry stocking (based on eligibility criteria)

Transportation – only required if member has an unmet transportation need

- What type of transportation assistance does the member need?
- For what activities does the member need help with transportation?
- Does the member already receive any transportation services?

Additional questions as needed: SCN Lead Entities and their IT Platforms may also add additional questions as desired to support more effective and comprehensive referrals, such as questions about income level, scheduling needs, delivery instructions, or the member's existing care management. For example, members who indicate that they are currently receiving care management (such as from an MCO or Health Home) the Social Care Navigator can opt to collect the care manager's contact information from the member and coordinate HRSN service delivery with an existing care manager.

Follow-up questions for FFS and MMC non-enhanced population (not eligible for Enhanced HRSN Services)

A subset of assessment questions is required in the IT Platform EA for Social Care Navigators to ask FFS and non-enhanced members in order to direct them to existing state, federal, and local resources that are appropriate based on their need.

Figure 5-3: Follow-up questions to understand a member's unmet needs

If member has an unmet need in a domain ✓ Required follow-up question		**MMC** (Enhanced population)	**MMC** (Non-Enhanced population)	**FFS**
General	1 Is the member enrolled In TANF (OTDA)? ft the member Is enrolled in Managed Care and eligible tor TANF, the Social Care Navigator can assist with a TANF application	✓	✓	✓
	2 What is the members current employment status?	✓	✓	✓
	3 Does the member have income from any source?	✓	✓	✓
	4 How many people are in the members household?	✓	✓	✓
Housing *only if unmet housing need*	5 What type or housing assistance does the member need?	✓	✓	✓
	6 Is their household currently working with a housing provider?	✓		
	7 Is the member on any housing waitlists (i e.. HUD, Section 8, local housing authority. or other voucher programs) or receive a rental subsidy?	✓	✓	✓
Nutrition *only if unmet nutrition need*	8 Is the member enrolled In SNAP (OTDA) and IMC? If the member Is enrolled in Managed Care and eligible for SNAP or IOQC, the Socia/ Care Navigator can assist with an application	✓	✓	✓
	9 Is the member receiving any home-delivered meals or food services?	✓		
	10 Is the member currently receiving nutritional counseling or education?	✓		
	11 How many people in the members household need food assistance?	✓		
	12 Does the member have the ability to store rood. such as a refrigerator?	✓		
	13 Does the member have cooking supplies such as pots. pans. utensils. plates. etc.?	✓		
	14 Does the member have any dietary restrictions or food allergies?	✓		
	15 Can you prepare and serve adequate meals either by yourself or with the help of a caregiver?	✓		
	16 Would you or a caregiver be able to prepare and serve adequate, nutritious meals It supplied with Ingredients and nutrition?	✓		
Transportation *only if unmet transportation need*	17 What type of transportation assistance does the member need?	✓	✓	✓
	18. For what activities does the member need help with transportation?	✓		
	19. Does the member already receive any Transportation services?	✓		

Step 7. Confirm the member's eligibility for Enhanced HRSN Services, including confirming Social Risk Factors and ensuring there is no service duplication

Using information from the member interaction as well as the Enhanced Services Member File and the Operations Manual, the Social Care Navigator needs to confirm that the member is eligible for one or more Enhanced HRSN Services and is not already receiving duplicative services. Members do not need to be asked to confirm information that is already marked with a "Y" on the ESMF file.

The Social Care Navigator should check that the member meets Social Risk Factors and clinical criteria *(for additional details, see HRSN Services)*. Only criteria pertaining to relevant Enhanced HRSN Services should be checked.

Members must meet the Social Risk Factors related to their unmet need in Table 5-14 Social Risk Factors. This step can be part of the overall eligibility check, but the member meeting the Social Risk Factor must be documented either within the Eligibility Assessment or within the Social Care Plan.

Some Social Risk Factors, such as meeting the HUD definition of homelessness, require additional information from the member to confirm the Social Risk Factor.

a. Homeless verification (part of Medical Respite, Rent / Temporary Housing, Utility Setup / Assistance, Pre-Tenancy/Tenancy Supports, Community Transitional Supports, Housing Transition and Navigation): The Social Care Navigator will ensure that the member meets the HUD definition of homeless or at-risk of homelessness. See Table 5-16 for the documentation requirements. The Social Care Navigator will document the member's current housing status and social risk eligibility within the IT Platform workflow of the Eligibility Assessment and upload documentation (if applicable). If this feature is not available yet in the platform, the Social Care Navigator should document the social risk criteria in the Social Care Plan.

After confirming eligibility (including Social Risk Factors), the Social Care Navigator should check for service duplication. This should include reviewing Screening data to understand what benefits or services the member is currently receiving, reviewing the Enhanced Services Member File for existing services being received, and confirming the receipt and nature of services with the member to assess whether there is duplication.

A related federal or state benefit is not necessarily a duplication of services with an Enhanced HRSN Service. For example, enrollment in a federal benefit such as SNAP or WIC is not considered duplicative of receiving 3.2 Medically Tailored Meals or Clinically Appropriate Home Delivered Meals, 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions, and 3.4 Fresh Produce and Non-Perishable Groceries even though each involves food. SNAP and WIC are designed to mitigate food insecurity for a household, whereas services 3.2 Medically Tailored Meals or Clinically Appropriate Home Delivered Meals and 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions must be approved by an RDN/CDN and are designed to improve health outcomes and 3.4 Fresh Produce and Non-Perishable Groceries is designed to supplement weekly food for high-risk children under 18 and pregnant / postpartum persons with identified food insecurity. Social Care Navigators can assist members with applications to SNAP and WIC and/or other state programs involving food.

Healthy Homes Pilot Considerations:

- A "Y" indicator for the Healthy Homes field on the ESMF flags to the Social Care Navigator that the member's household consented to participate in the pilot and completed at least an initial asthma and/or dwelling visit under the Healthy Homes Pilot. Further discussion with the member is required to

understand the extent of Pilot home improvement services delivered to the household and to determine whether additional supports under Asthma Remediation are warranted.

- If a member has a "Y" indicator on the ESMF for this data field and the Social Care Navigator needs to learn more, the Social Care Navigator should ask the member: Did your household receive home improvement services under the NYS Healthy Homes Pilot? If the member answers yes, the Social Care Navigator should ask for additional details regarding the type/extent of home improvement services received and consider these in the context of appropriate Enhanced HRSN services from the SCN Program.
- For guidance on how Social Care Navigators should identify potentially duplicative services, see Table 5-45: Waiver- and program-specific Social Care Navigator workflows, which provides program-specific instructions.

MLTCP/MAP Considerations:

- For Housing - 2.1 Home Accessibility and Safety Modifications: If MLTCP or MAP are flagged on ESMF under MBR_LOB_Desc or if member verbally attests to program enrollment, the Social Care Navigator should ask for additional details for Housing services received. The Navigator should consider the member's current services prior to referring them to additional Enhanced HRSN services. Member discussion should be noted in the member's Social Care Plan.

Step 8. Confirm that the Medicaid Managed Care member wants to receive Enhanced HRSN Services for which they are eligible and inform member of potential COI, if relevant

The Social Care Navigator should inform the member which Enhanced HRSN Service(s) they are eligible for and ask the member if they would like to receive these services. If not, end the Eligibility Assessment.

In the event that the entity conducting Navigation (the SCN Lead Entity or contracted HRSN service provider) navigates and also provides Enhanced HRSN services, members should be verbally informed of this dual role and also be provided a statement about Freedom of Choice. Verbal statements should convey that members do not have to use the SCN Lead Entity or HRSN service provider with dual role of Social Care Navigator/provider and when applicable and available the members are provided options and member preference must be considered first (*see SCN Conflict of Interest Plan*).

Social Care Navigators should document in the Social Care Plan that Freedom of Choice was verbally provided to the member during the Eligibility Assessment.

Step 9. Complete a Social Care Plan that auto populates with existing member information and is tailored to the Medicaid Managed Care member's specific needs

Social Care Plans should automatically populate for Medicaid Managed Care members (*see Social Care Plans*). Social Care Navigators should review and further tailor the Social Care Plan to support the member's needs. Member goals identified in Social Care Plans will be mapped to SNOMED Goal Codes by the SCN IT Platform (*see Eligibility Assessment Coding*).

All historical member data within the SCN IT Platform system, including any initiated, partially completed, or completed Eligibility Assessments, must be retained for at least ten years, unless intentionally changed or deleted by the SCN Lead Entity or their contracted Social Care Navigators.

iii. Ending an Eligibility Assessment

An Eligibility Assessment will only be considered "complete" if all data elements specified as "required" in the MVD and all associated resources specified as "required" by the FHIR IG are properly submitted in FHIR bundles. Please view NYeC website section 1.10 for MVD specifics here: https://shinny.org/us/ny/hrsn/index.html.

There are specific statuses needed to ensure a finished and complete Eligibility Assessment including:

- Encounter Status=Finished
- Condition Status=Confirmed

iv. Situations in which a member does not respond to outreach for Eligibility Assessment

If the member does not respond to outreach from a Social Care Navigator to conduct an Eligibility Assessment after identifying unmet HRSNs in the Screening, the Social Care Navigator is required to:

- Make at least three (3) outreach attempts within five (5) business days across daytime, evening, and weekend hours
- Conduct outreach activities across multiple modalities (e.g., phone call, text, e-mail)
- Document each attempted outreach in the SCN IT Platform's Social Care Plan

~~Outreach to the member will not be reimbursed.~~ Social Care Navigators may bill for member and non-member facing time spent on the Eligibility Assessment, Navigation, and Enhanced Care Management; however, time spent trying to reach a member will not be reimbursed.

v. Considerations for children, youth, and households

Delivery of services to members in the same household: OHIP expects that SCNs help address the needs not just of individuals but other individuals in their households where possible. Eligibility for Enhanced HRSN Services is based on individual Screening results and individual Eligibility Assessments for each member within a household. A member's eligibility for Enhanced HRSN services is not impacted by whether other family / household members are eligible or receiving Enhanced HRSN services, or by whether other family / household members are eligible for Medicaid.

Social Care Navigators should work with members to understand who is part of their household. Social Care Navigators should follow up to understand if other individuals in the member's household are eligible for Enhanced HRSN services. Social Care Navigators should document household size and other individuals residing in a member's home in the member's Social Care Plan. Other individuals in the household may impact how certain services are delivered (*see Table 5-6 for additional details*). OHIP plans to provide technical guidance on functionality to link members within a household with other individuals eligible for Enhanced HRSN services in an upcoming quarter. This guidance is intended to help SCNs and IT platform vendors develop workflows for tracking and billing for services for members in the same household. In the interim, OHIP understands SCNs and IT platform vendors will utilize current workflows and workarounds for delivery and billing of services for members in the same household.

A household includes the eligible Medicaid member(s) and the following individuals residing at the same residential address: their parent or legal guardian (if the member is under the age of 18), their spouse or domestic partner (as defined in Section 2994-a of the New York Public Health Law or any successor statute), dependents, and children under the age of 18. Children include adopted, biological, and stepchildren, as well as children under court or legal order establishing custody.

- Unless the individual is also a Medicaid member and individually eligible for Enhanced HRSN Services, the following individuals are NOT included in a household: live-in aides, unrelated persons living together (e.g., roommates, friends), additional family or relatives (e.g., aunt, uncle, sister, nieces/nephews), short-term foster children

Services delivered to a home (e.g., Medically Tailored Meals) must be delivered to a residence owned, rented or leased by the member or their primary caregiver.

Table 5-6: Household guidance for Social Care Navigators and HRSN Service Providers

Service category	Services	Guidance
Housing	**2.1 Home Accessibility and Safety Modifications**	• Social Care Navigators will authorize services that are required to address the HRSNs of the individual member, which may include both individual spaces (e.g., member's bedroom) and shared spaces within the home. • Each member is eligible for services up to the member-level cap • Where relevant, Social Care Navigators should refer eligible members within the same household to the same HRSN service provider in order to streamline dwelling assessments and Statement of Work (SOW) development (e.g., one dwelling assessment can be conducted at the home to address the needs of multiple eligible members) • Invoices should be submitted for each individual eligible member in a household and costs for all service components (including dwelling assessment) should be appropriately divided across invoices for each member • Social Care Navigators should document other eligible members residing in a member's home in the member's Social Care Plan • OHIP will be monitoring spending by household for these services
	2.2a Home Remediation Service: Mold and Pest Remediation	
	2.2b Home Remediation Service: Ventilation Improving Systems	
	2.2c Home Remediation Service: Equipment Provision	
	2.3b Asthma Remediation and Supportive Products	
	2.5 Rent / Temporary Housing (Rental Subsidy and Back Rent)	• Members who are eligible to receive rental assistance may receive assistance for a unit size

Service category	Services	Guidance
		that accounts for other individuals in their household (up to 1 bedroom per individual in the household; spouses and domestic partners are expected to share a room) • Social Care Navigators should work with eligible members to understand how many individuals are in the member's household • Social Care Navigators should document household size in the member's profile and household details within the Social Care Plan to ensure household size and relevant information is communicated to HRSN service providers for members to receive assistance for the appropriate unit size for their household • Where feasible and appropriate, eligible members residing in the same household should be referred to the same HRSN service providers for services • In situations where multiple members eligible for Rent / Temporary Housing services are residing in the same household, invoices should be submitted for a single member of each household
	2.6a Utility Setup – Activation Expenses **2.6b Utility Setup – Back Payment** **2.6c Utility Assistance**	• Coverage for phones is intended to be for landlines. In the event that a member uses a cellular phone in place of a landline, cellular phones are limited to one phone plan per household, even if the household includes multiple eligible members • Minors under the age of 18 years are not eligible for cell phone coverage. For members who are enrolled in a cellular phone 'family plan', utility services will cover the equivalent of one cellular phone line • Where feasible and appropriate, eligible members residing in the same household should be referred to the same HRSN service providers for utility services • Fee schedule caps for utility services were developed to cover expenses for an average-size household. OHIP therefore expects that in general, total utility expenses for eligible

Service category	Services	Guidance
		members residing in the same household will NOT exceed per-member caps for utility services • When feasible and appropriate, invoices for all utility services delivered to a given household should be submitted for one individual member in a household (e.g., utility services for a family with multiple eligible members should be invoiced under only 1 of the members) • When needed (e.g., when members living in a household are not related), HRSN service providers may distribute utility invoices across multiple members of the same household (e.g., heating expense may be invoiced under one member and electricity expense may be invoiced under another member) • It is up to SCN Lead Entities to ensure appropriate expenditure for utility services if multiple eligible members reside in the same household
	2.8a Community Transitional Supports (CTS)	• CTS services will be provided at the household level (i.e. one unit of service per household), as CTS components (e.g., security deposit, pantry stocking) have been estimated based on unit size. As part of the Enhanced HRSN Care Management process, the Social Care Navigator will determine whether other individuals in a member's household are already receiving CTS services through the SCN program and avoid providing duplicative services to members sharing a household • Where feasible and appropriate, eligible members residing in the same household should be referred to the same HRSN service providers for services • In situations where multiple members eligible for CTS services are residing in the same household, invoices should be submitted for a single member of each household
Nutrition	**3.2a Medically Tailored Meals and 3.2b Clinically Appropriate Home Delivered Meals**	• Social Care Navigators should refer all eligible members residing in the same household to the same HRSN service provider, where possible, in

Service category	Services	Guidance
	3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions **3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)**	order to facilitate efficient food delivery (e.g., streamlining delivery costs) • Social Care Navigators should document other eligible members residing in a household in the member's Social Care Plan and communicate this information to HRSN service providers • Individuals who meet the criteria below may qualify for additional Nutrition services to address the nutrition needs of other individuals in their household: • Eligible for Nutrition services (per social risk and clinical criteria), and • Part of one of the following enhanced populations: (A) pregnant or postpartum persons or (B) high risk child under the age of 18 • Members eligible for Nutrition services who fall into either of the enhanced populations above may receive additional nutrition support for members of their household who meet the following criteria: • The household definition criteria in Section D. v. Considerations for children, youth, and households • Have an unmet HRSN in the Nutrition domain as determined by Screening • Are enrolled in Medicaid Managed Care (but do not need to meet Enhanced Population or clinical criteria for Nutrition services) • Social Care Navigators should screen and perform an Eligibility Assessment (including questions 1-4) for all additional household members who meet the above criteria to determine if they are individually eligible for services • If the additional household member is independently eligible, they should be individually referred to Nutrition services, and billing for those services should follow the normal process

Service category	Services	Guidance
		• If the household member is NOT independently eligible for Nutrition services, the Social Care Navigator may: • Navigate the member to existing federal, state, and local resources, OR • Communicate to the service provider that additional food can be provided to the eligible member to accommodate the need of additional household member(s). Per the HSRN Fee Schedule, household modifier "TT" should be included on the invoice for Nutrition services to indicate that food was provided to support multiple individuals in the same household. Only the eligible member should be referred to Nutrition Services. • Reimbursement for Nutrition services provided to additional household members must comply with the per member service limitations and rate ranges provided in the HRSN Fee Schedule • For example, if one eligible member and one additional household member receive Food Prescription boxes, they would receive in total two boxes and reimbursement for each individual food box must be within the HRSN Fee Schedule rate range

Children and youth residing in multiple homes:

- *Delivering services to multiple homes:* Members under the age of 18 who are eligible for Enhanced HRSN Services and reside in multiple homes may receive services at each home of a parent or legal guardian in which they spend a considerable amount of time (this does not apply to homes of relatives and other adults). Enhanced HRSN Services provided to multiple homes must not exceed the per-member service caps outlined in the fee schedule where relevant (e.g., for Home Modifications).

  What qualifies as a considerable amount of time may vary based on the member's living situation, needs, and the nature of services. Social Care Navigators should make a determination regarding which Enhanced HRSN Services need to be provided at multiple homes.

  During the Eligibility Assessment process, Social Care Navigators should do the following for members under the age of 18:

- If member is under 10 years old, ask parent / legal guardian if the child spends a considerable amount of time at multiple households
- If member is 10 or above, ask the member or their parent / legal guardian if they spend a considerable amount of time at multiple households
- Document responses in the member's Social Care Plan

- *Documentation required:* Before authorizing services at multiple homes, Social Care Navigators must obtain documentation confirming that a member under the age of 18 spends a considerable amount of time at multiple homes of a parent or legal guardian. Acceptable documentation includes but is not limited to a custody agreement, court-ordered parenting plan, mediation agreements, joint-custody affidavit, school registration that lists "address of record", lease or rental agreement that lists the child as a tenant, food stamp documentation, general assistance documentation, or Temporary Assistance for Needy Families documentation. Social Care Navigators should work with parents / legal guardians to identify appropriate documentation and upload documentation in the SCN IT Platform.

- *Billing services for children living in multiple households:* For children in multiple households who may receive the same service on the same day (or date range) from the same provider at multiple households, the 'concurrent claim' modifier -76 should be added when submitting the claim. The modifier only needs to be added to claims beyond the first to avoid claims auto-rejection from MCO systems.

Additional considerations for Transportation services:

- For situations where a child/youth is eligible for Enhanced HRSN Services, but their parent or legal guardian is not, NYHER will reimburse the transportation costs of one parent or legal guardian to accompany the child. NYHER will not reimburse additional transportation costs for additional non-eligible minors in the household.
- For situations where a parent or legal guardian is eligible for Enhanced HRSN Services, but their children are not eligible, NYHER will reimburse the transportation costs for one minor if they need to accompany the parent / legal guardian (e.g., due to lack of available childcare).

Considerations for SCN service delivery for children in the foster care system

Children in foster care who meet requirements as outlined in Table 5-7 Enhanced Populations may qualify for Enhanced HRSN Services. This includes:

a. Children in family foster care home (i.e., temporary or long-term placements in a foster family's home)
b. Children or youth transitioning out of foster care (i.e., those aging out of foster care or reuniting with their family)

Note, children in congregate care (i.e., children in OCFS residential settings) are not eligible for reimbursed Screening, Navigation, or Enhanced HRSN Services. However, SCN LEs should still form partnerships with congregate care entities and, where applicable, establish workflows to assist with discharge planning.

Process to address unmet HRSNs for children in the foster care system

1. **Children in family foster care home:** In general, it is the responsibility of county and 29-I agencies to ensure the HRSNs of children in family foster care home are met, given that counties / agencies are required to meet the needs of children in family foster homes such as shelter, food, clothing, and transportation. Social Care Navigators should work with county and 29-I agencies to ensure that resources of county and 29-I agencies have been exhausted before children receive Enhanced HRSN services through the SCN program.

   During an Eligibility Assessment, the Navigator should determine and document if the child is in family foster care home by asking the child and / or their caregiver. If the child is in family foster care home, the Navigator should ask for the child and / or their caregiver for the foster care caseworker's contact information.

   Social Care Navigators should then contact the foster care caseworker to ensure all county and 29-I agency resources have first been exhausted. If the child has needs beyond what county or agency resources provide, the county or 29-I agency should confirm with the Navigator that the child may receive services from the SCN program. The Social Care Navigator can then move forward with navigating the child to relevant Enhanced HRSN Services through the SCN program.

2. **Children or youth transitioning out of foster care**: During an Eligibility Assessment, the Navigator should determine and document if the child is transitioning out of foster care by speaking with the child and / or their caregiver. If the child is transitioning out of foster care, Social Care Navigators may move forward with navigating the child (and their family if relevant under Table 5-6 Household Guidance) to Enhanced HRSN Services through the SCN program. The Navigator does not need to engage with the foster care caseworker and does not need to receive a service justification from the county before proceeding.

Table 5-7: Guidance for Social Care Navigators for children in the foster care system

Population	Context	Guidance for Social Care Navigators
(a) Children in family foster care home *Temporary or long-term placement in a foster family home*	• Foster care boarding rates cover shelter, food, clothing, and transportation • Children in family foster care home may receive Screening, Navigation, or Enhanced HRSN Services reimbursed via NYHER if they have needs beyond what counties and 29-I agencies provide	• Determine and document whether the child is in family foster care home by asking the child and / or their caregiver during the Eligibility Assessment • Double check that the child is in family foster care, and not congregate care / an OCFS residential setting • Ask the child / their caregiver for their foster care caseworker's contact information • Contact the foster care caseworker to discuss the needs identified during the Eligibility Assessment, and ensure all county and 29-I resources have first been exhausted to address those needs • If the child has needs beyond what the county / agency provides, ask the county

Population	Context	Guidance for Social Care Navigators
		or 29-I agency contact to confirm that county resources have been exhausted and the child may receive services from the SCN program • Proceed with navigating the child to relevant Enhanced HRSN Services through the SCN program
(b) Children or youth transitioning out of foster care *Youth up to age 21 who are leaving the foster care system due to (1) age or (2) family reunification*	• OCFS and other state and local programs offer some services to enrolled youth, but enrollment is not guaranteed and varies (e.g., Chafee Foster Care Program, ACS Housing Subsidy Assistance) • Children transitioning out of foster care may receive Enhanced HRSN Services for which they are eligible	• Determine and document whether the child is transitioning out of foster care (i.e., aging out of foster care or reuniting with their family) • If transitioning out of foster care, move forward with navigating the child (and their family if relevant under Table 5-6 Household Guidance) to Enhanced HRSN Services through the SCN program
(c) Children in congregate care *OCFS residential settings*	• Children in institutional or residential facilities (including OCFS Congregate Care) cannot receive Screening, Navigation, or Enhanced HRSN Services reimbursed via NYHER	• Determine and document whether the child is in congregate care by asking the child and / or their caregiver • If in congregate care / an OCFS residential setting, do not provide any Navigation or Enhanced HRSN Services through the SCN program. Encourage the child and / or caregiver to engage with their foster care caseworker to ensure county or 29-I agency resources are meeting all HRSNs

vi. Considerations for criminal justice-involved individuals and justice-involved youth

OHIP recognizes that criminal justice-involved individuals and justice-involved youth are particularly vulnerable populations, especially individuals with co-occurring conditions, who must maintain connectivity and access to critical services and medications as they transition back to community settings. OHIP aims to ensure access to care and improve outcomes for these populations, including through provision of Enhanced HRSN services such as housing, food and nutrition, and transitional supports.

MMC members *who are up to 90 days post-release from incarceration* and have a chronic condition (including but not limited to Substance Use Disorder, Serious Mental Illness, and hepatitis C) and high-risk justice-involved youth (under the age of 18) with an identified unmet health-related social need may be eligible to receive Enhanced HRSN Services through the SCN program *(see Table 5-12: Enhanced Population Descriptions for*

additional detail on eligibility criteria). SCNs are expected to conduct proactive outreach and support eligible individuals within these populations to receive Enhanced HRSN services.

Per the Social Security Act (SSA) and the Consolidated Appropriations Act, 2023 (CAA), Medicaid is typically suspended **during incarceration** (SSA) and then reactivated up to 30 days prior to release (CAA). Members are initially reactivated into Medicaid FFS and then enroll in Medicaid Managed Care 30 to 120 days after release from an incarceration facility. The timing of Medicaid reactivation may depend on the member's age, foster care history, or whether the member is in a federal or state prison, a juvenile detention center, or a county jail.

Considerations for Criminal Justice-Involved Adults: Adult MMC members who are up to 90-days post release from incarceration and who have a diagnosis of a chronic condition (including but not limited to Substance Use Disorder, SMI, and hepatitis C) and an unmet HRSN are eligible for Enhanced HRSN services. OHIP envisions that these individuals will:

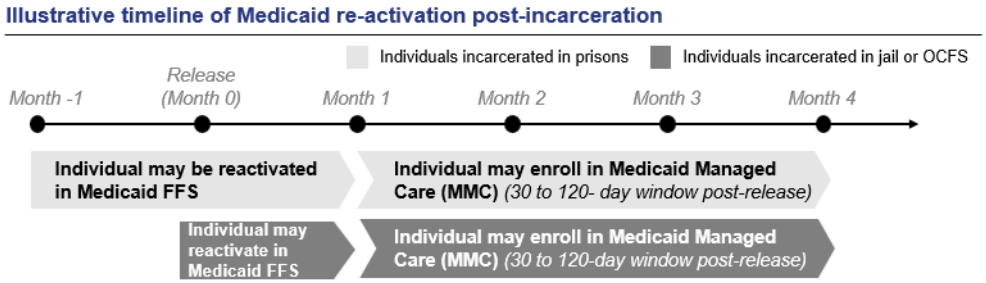
- Receive HRSN Screening post release if Medicaid FFS is active so that they can be navigated to appropriate social care services based on eligibility. For example, a member can be initially screened as Medicaid FFS member after release either in coordination with the SCN LE or their contracted network (e.g. Health Homes) or by use of the self-screening tool on SCN LE websites and
- (Re)enroll in MMC once eligible in order to be able to receive Enhanced HRSN Services as appropriate during the 90-day window. For example, in coordination with the SCN LE network a Social Care Navigator could follow-up with the member and either assist with MMC enrollment if needed or if member is already enrolled in MMC, could re-screen the member as a MMC member and complete an Eligibility Assessment for potential eligibility and access to Enhanced HRSN Services.

OHIP encourages SCN Lead Entities to partner with jails, prisons, and Health Homes in their region to support members to receive HRSN Screening upon release. Jails and prisons do not need to be included in the Network (i.e., contracted with the SCN Lead Entity) but are essential SCN program partners.

SCN Lead Entities may take different approaches to accomplishing OHIP's vision for this population, including:

- SCN Lead Entities may work with ecosystem partners to ensure that individuals are referred to the SCN for Screening in a timely manner following release (e.g., establishing relationships with discharge planners and/or case managers in order to ensure continuity of support for individuals)
- SCN Social Care Navigators may assist members in the transition from FFS to MMC by providing contact information for individuals trained in Medicaid enrollment (e.g., MCO enrollment counselors, NY Enrollment Counselors). Social Care Navigators are not expected to support members to fill out enrollment paperwork and forms
- SCN Lead Entities are strongly encouraged to include in their Networks HRSN service providers that specifically serve criminal justice populations and engage with individuals immediately after release in order to help them transition to MMC and also receive Screening
- SCN Lead Entities can support this partnership by providing materials (such as SCN program and contact information) for network partners to distribute to facilities, member, and member's care team encourage outreach to Social Care Navigators upon release

Figure 5-4: Illustrative timeline of Medicaid re-activation post-incarceration



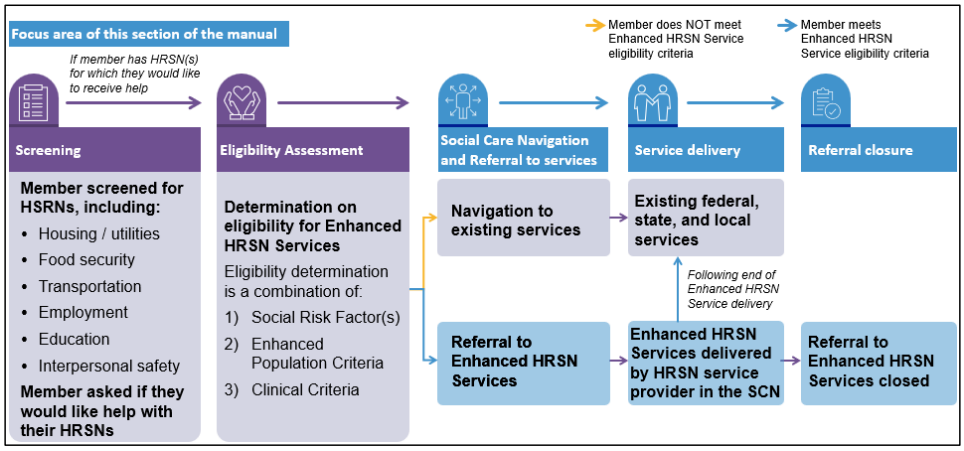
*Note post-release criminal justice population can only be offered Enhanced HRSN services if enrolled in MMC, up to 90 days post-release from incarceration with a chronic condition.

Considerations for Justice-Involved Youth: OHIP is committed to strengthening the physical, mental, and social well-being of NYS children and youth. Justice-involved youth are a particularly vulnerable population with significant physical and behavioral health needs and challenges in access to care. OHIP aims to support high-risk members of this population *(see Table 5-12: Enhanced Population Descriptions for additional detail on eligibility criteria)* through Enhanced HRSN services to improve stable transitions out of prisons, jails, juvenile detention and youth correctional facilities and promote improved population health and health equity outcomes.

SCNs are expected to work with organizations including juvenile detention and youth correctional facilities as an ecosystem partner to meet the unique needs of juvenile-justice involved members. Juvenile detention and youth correctional facilities do not need to be included in the Network (i.e., contracted with the SCN Lead Entity).

SCNs will be expected to work with providers of case management services to support Screening and Social Care Navigation for justice-involved youth after release from an institution.

e. SCN REFERRALS



i. Referrals overview

Referrals to Enhanced HRSN Services are a core element of this program, wherein Social Care Navigators connect eligible members to services, care providers, and community resources. These are Closed Loop Referrals, meaning that when a member is referred for Enhanced HRSN Services, the Social Care Navigator will coordinate the member's connection to available resources and follow up to ensure services were rendered. In order for SCN IT platforms to have Closed Loop Referrals, specific statuses and tasks must be used throughout the referral journey.

This section outlines:

- **SCN Referral Process**: Programmatic process for how referrals are made to HRSN service providers from initial referral through service completion and referral closure
- **SCN Referral Tracking**: Data tracking elements to ensure accurate information collection
- **Distribution of referrals across the Network:** How Social Care Navigators distribute referrals among HRSN service providers

ii. Referral workflow with SHIN-NY data requirements

The referral workflow, from initial referral request through HRSN service delivery and referral closure, is detailed below. Please also refer to the NYeC website for additional technical requirements for SCN IT Platforms to integrate to ensure SHIN-NY data is accurate and processed: https://shinny.org/us/ny/hrsn/index.html.

Each **SCN Lead Entity can specify its own standards for how a referral is sent**, either as a:

a. Direct referral point-to-point to an individual HRSN service provider, OR
b. A general "broadcast" from the Social Care Navigator to the Social Care Network

"Priority" or "Urgent" needs workflows:

Social Care Navigators should be educated to determine priority and urgent needs of members on a case-by-case basis when severe and immediate needs are identified through Screening and/or Eligibility Assessment. For example, the Social Care Navigators must prioritize issuing referrals for members that are experiencing interpersonal safety concerns as identified during the eligibility assessment. If the member wants assistance, the referral must be issued as close to the same day of the eligibility assessment as possible. Additionally, when Social Care Navigators receive an external referral for Medical Respite, the Social Care Navigator must prioritize these referrals to ensure members are connected with an appropriate Medical Respite provider within 2 business days.

~~The SCN Lead Entity may choose to design its own workflow to address priority members with severe and immediate needs as identified through Screening and/or Eligibility Assessment (e.g., physical safety concern due to interpersonal violence, immediate need for food and/or shelter, etc.), or in instances in which a provider flags a member's need as "priority" or "urgent". In these instances, the SCNs may choose to utilize optional functionality within their IT Platform to tag high priority members. OHIP will NOT require that SCNs establish this type of workflow or IT Platform functionality.~~

Navigation to existing local, state or federal services:

~~For members that are being navigated to existing local, state or federal services (e.g., interpersonal safety services), NYeC would expect to see a service request via FHIR but not a closed "Task". There is not an expectation for tasks or procedures to be associated with navigation to local, state or federal services.~~

OHIP requires Social Care Navigators to utilize SNOMED descriptions per the Social Care Coding document and update the FHIR service request to "Completed" after a member agrees to be navigated to ANY local, state or federal service.

OHIP will require reporting accuracy for SNAP, WIC, TANF, local, state and federal housing assistance programs. Please see Section k. Partnerships.

As a best practice, if a provider is on the SCN IT Platform to accept referrals for local, state or federal services then the provider should utilize the statuses in Table 5-8 below.

iii. Referral to Enhanced HRSN Services

Step 1. Social Care Navigators are responsible for verifying the member's Medicaid eligibility via MEVS on the day of initiating referrals for Enhanced HRSN Services

Step 2. A Member may be contacted for service navigation if the referral is not being conducted in the same visit as the Screening and/or Eligibility Assessment

Step 3. A member approves desire for service navigation or referral to Enhanced HRSN services

The **Social Care Navigator will document the member's consent for service and input notes into the member's Social Care Plan** relative to their approved service(s) that will be visible to contracted organizations that accept the referral for provision of Enhanced HRSN Services.

~~The Social Care Navigator can refer the member to Enhanced HRSN Service(s) while waiting for a provider attestation (**Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service.**) or other documentation to verify eligibility for another service.~~

NOTE: After a Social Care Navigator verifies the member's unmet needs, Enhanced Population, clinical criteria and/or social risk criteria, then the Social Care Navigator should refer the member to eligible Enhanced HRSN Services and ~~At this time, the Social Care Navigator can~~ move the referral(s) from "Draft" task state into "Requested". Members should be referred to eligible Enhanced HRSN Services even if the Social Care Navigator is waiting for proof of attestation or documentation to support approving a referral for a different Enhanced HRSN service per **Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service(s)**.

For example, a Social Care Navigator should proceed with sending a referral for Medically Tailored Meals for an eligible member who has an unmet Nutrition need, even if the Social Care Navigator is holding back a referral for Home Accessibility and Safety Modifications in anticipation of a provider attestation for proof of a physical disability.

Step 4. A Service Request is sent to HRSN service providers or to service navigation and a copy to the SHIN-NY

Each referral will be associated with a specific Enhanced HRSN Service (i.e., members who are eligible for multiple Enhanced HRSN Services will have a separate referral for each Service).

Upon receiving a referral for an Enhanced HRSN Service, the HRSN service provider can accept, reject, or not respond to the referral (*see Table 5-8*).

Table 5-8: Required referral status changes for Social Care Navigators and HRSN service providers

The below statuses are used in data the SHIN-NY receives and may already be automated in the SCN IT Platforms.

Role	Options for HRSN service provider actions	Considerations
Social Care Navigator	Draft	The task is not yet ready to be acted upon
Social Care Navigator	Requested	The task is ready to be acted upon and action is sought
HRSN Service Provider	Accepted	The HRSN service provider has agreed to execute the task but has not yet started work
HRSN Service Provider	Rejected	The HRSN service provider has decided not to execute the referral prior to performing any action.
Social Care Navigator/HRSN Service Provider	Canceled	The task was not completed
HRSN Service Provider	In Progress	The task has been started but is not yet complete

HRSN Service Provider	On Hold	The task has been started but work has been paused
HRSN Service Provider	Failed	The task was attempted but could not be completed due to some error
Social Care Navigator	Completed	The task has been completed

Technical considerations across HRSN service provider action options within SCN IT Platform:

- The timestamp of the referral being updated will be collected across all options of HRSN service provider responses to a referral
- Any narrative reasoning for rejecting the referral provided by the HRSN service provider in the referral Task does not meet FHIR standards and would not be transmitted to the SHIN-NY Data Lake

Step 5. The HRSN service provider accepts the Service Request through a Task

Step 6. The HRSN service provider contacts the member

Upon accepting the referral, the HRSN service provider conducts outreach to the member to initiate service delivery. In many cases, the first step may be additional information gathering by the HRSN service provider (for example nutritional information to inform Medically Tailored Meals).

If an Enhanced HRSN Service is successfully initiated by the HRSN service provider, the HRSN service provider updates the status of the referral on the SCN IT Platform to “In Progress”. OHIP anticipates the Service Request status remains as “active” for the duration of the “In progress” fulfillment status.

If during the course of service delivery, the HRSN service provider learns of another unmet HRSN that was not identified during the initial Screening, the HRSN service provider cannot directly submit an additional referral for relevant services. The member would need to be directed to their Social Care Navigator to be re-screened (and member must be eligible for a Re-Screening) to be navigated to additional services.

If a member does not respond to outreach from the contracted HRSN service provider, either for an initial conversation to initiate service delivery or after service delivery begins but before it is completed, the contracted HRSN service provider is required to make the following outreach attempts:

- Make at least 3 outreach attempts within 5 business days (Note: attempting outreach alone is not reimbursable)
- Conduct outreach across multiple modalities (e.g., phone call, text, e-mail)
- Document each attempted outreach in the SCN IT Platform’s Social Care Plan

If the HRSN service provider is unable to initiate service delivery, the HRSN service provider is encouraged to include a narrative reasoning for not delivering the service in the referral Task on the SCN IT Platform alongside updating status to the relevant of “Cancelled”, “Rejected” or “Failed”.

Considerations for successful and unsuccessful initiation of Enhanced HRSN Services are outlined below.

Step 7. Then the Task can be updated to show this work is “In-progress”, this data is then sent to the SHIN-NY

If the member is receiving ongoing Enhanced HRSN Services such as Housing and Nutrition, their Social Care Navigator should conduct outreach prior to Enhanced HRSN Service delivery completion (see Table 5-9 for contact timeline expectations per received Enhanced HRSN Service). These contact points are intended to:

- Determine if Enhanced HRSN Services are meeting member needs
- Support in transitioning the member to additional supports after the end of Enhanced HRSN Service Delivery (e.g., existing federal programs), where relevant and desired. For example, if a member is receiving the Nutrition Enhanced HRSN Service of Fresh Produce and Non-perishable Groceries (Pantry Stocking), the Social Care Navigator should consider offering to transition the member to an existing service such as WIC or SNAP where applicable

Social Care Navigator engagement with members is a reimbursable activity under Care Management. Social Care Navigator attempts to contact members (if member is not directly engaged) do NOT count as reimbursable care management.

Step 8. Service marked as complete

When the service is completed, the HRSN service provider marks the Task to be “complete”, attaches a procedure with a provision of service code, and the SCN Lead Entity marks the Service Request as “complete”. Finally, a copy of this is sent to the SHIN-NY.

A completed service includes:

- Encounter Status=Finished
- Service Request Status=Completed
- Task Status=Completed
- Procedure=Completed

Step 9. Social Care Navigator conducts outreach after service completion

Within 5 days after completion of Enhanced HRSN Service, the member’s Social Care Navigator conducts outreach to the member (see Table 5-9 for contact timeline expectations per received Enhanced HRSN Service) to:

- Confirm service delivery completion, and
- Support in transitioning the member to additional supports (e.g., existing federal, state, and local programs), where relevant and desired

The SCN Lead Entity, contracted Social Care Navigator or HRSN Service Provider will update the status of the “ServiceRequest” in the SCN IT Platform to “Completed” upon completing delivery of the Enhanced HRSN Service. Updates to “ServiceRequest” and fulfillment request statuses are critical in downstream evaluation including but not limited to milestone and metric calculations.

Table 5-9: Member contact timelines at end of service delivery, per service type

HRSN Category	HRSN Service	Timing of contact before end of service delivery	Timing of contact after end of service delivery
Care Management	1.1 Navigation Services	Not applicable – not an Enhanced HRSN Service	
	1.2a Enhanced HRSN Care Management – Eligibility Assessment Level 2 Only	N/A	Within 5 business days after service completion
	1.2b Enhanced HRSN Care Management – Care Management Level 2 Only	N/A	Within 5 business days after service completion
Housing	2.1 Home Accessibility and Safety Modifications	N/A	Within 5 business days after service completion
	2.2 Home Remediation Service	N/A	Within 5 business days after service completion
	2.3 Asthma Remediation	HRSN service provider schedule final ASME visit with the member no earlier than 45 days after Asthma Remediation services have been provided to administer an asthma control test to evaluate the impact before and after service competed	Within 5 business days after service completion
	2.4 Recuperative Care (Medical Respite), Pre-Procedure and Post-Hospitalization	Medical Respite provider contacts member 14 days before service completion	Within 5 business days after service completion
	2.5 Rent / Temporary Housing (Rental Subsidy and Back Rent) for up to six months	Ongoing throughout service delivery to assist in transition to additional supports AND 60 days before service completion or as soon as possible for services delivered for <60 days	Within 5 business days after service completion

HRSN Category	HRSN Service	Timing of contact before end of service delivery	Timing of contact after end of service delivery
	2.6 Utility Setup / Assistance	N/A	Within 5 business days after service completion
	2.7 Pre-Tenancy Services	N/A	Within 5 business days after service completion
	2.8 Community Transitional Supports	N/A	Within 5 business days after service completion
	2.9 Tenancy Sustaining Services	N/A	Within 5 business days after service completion
	2.10 Housing Transition and Navigation Services	N/A	Within 5 business days after service completion
Nutrition	3.1 Nutrition Counselling and Education	60 days before service completion AND 10 days before service completion	Within 5 business days after service completion
	3.2a Medically Tailored Meals	60 days before service completion AND 10 days before service completion	Within 5 business days after service completion
	3.2b Clinically Appropriate Home Delivered Meals	60 days before service completion AND 10 days before service completion	Within 5 business days after service completion
	3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	60 days before service completion AND	Within 5 business days after service completion

HRSN Category	HRSN Service	Timing of contact before end of service delivery	Timing of contact after end of service delivery
		10 days before service completion	
	3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	60 days before service completion AND 10 days before service completion	Within 5 business days after service completion
	3.5 Cooking Supplies	N/A	Within 5 business days after service completion
Transportation	4.1 Transportation related to HRSN service or care management	N/A	Within 5 business days after service completion

iv. SCN referral tracking

Enhanced HRSN Service referrals will have a coding status that follows FHIR standards, allowing relevant member referrals and data to be to be transmitted to and from the SHIN-NY Data Lake. HRSN service providers will have process tasks within the SCN IT Platform associated with individual referrals that will automatically transmit relevant data from the QE to the SCN IT Platform such that the HRSN service provider has all necessary information to complete the process task. Conversely, HRSN service provider activity in process tasks (e.g., updating a referral's status to be accepted) will automatically be timestamped and transmitted from the SCN IT Platform to the SHIN-NY Data Lake.

The Social Care Plan and associated data elements that feed Performance Metrics will be created and automatically tracked during the referral activity.

- Data Reference: Referral Activities
- Data Output: Social Care Plan Creation, SNOMED Referral / Service and Goal Codes (required year 3)

Technical considerations:

- Referrals will be assigned an appropriate standardized SNOMED-CT referral code provided by OHIP;
- Each referral is a "ServiceRequest" by FHIR standards

The SCN IT Platforms must be capable of the following functionality and details in order to conduct and manage Closed Loop Referrals and service coordination between SCN Lead Entities and their Networks:

- Track where a member was referred
- Refer to Enhanced HRSN Services

- Referral Status *(see Artifact 4 & 5 of 1115 SHIN-NY FHIR Implementation Guide for specific referral statuses)*
- Time to Closed Loop Referral
- Details on services delivered (e.g., type of intervention, duration)
- Service Begin Date: SCN IT Platforms must allow for Social Care Navigators to utilize date of 1st service provision to calculate the service duration period when applicable (e.g., 6 months of MTM is based on date of 1st meal provision to the member)
- Service End Date: The end of HRSN service duration
- Total Service Units Allowed

OHIP plans to have all referral data:

- Flow from the SCN IT Platform through the SCN's designated QE partner to the NYeC/SHIN-NY data lake
- Track important information about the Network's referral closure rate
- Address any unmet Medicaid Managed Care member needs

The SCN Lead Entity will be responsible for reporting this information and additional performance detail monthly to OHIP (*discussed further in Performance and Payment section*).

v. Distribution of Referrals across Network

SCNs should strive to ensure a balanced distribution of referrals across organizations in the Network. Organizations providing both Navigation and HRSN service delivery are required to follow their SCN's conflict of interest plan to ensure they operate in the member's best interests (*see SCN Conflict of Interest Plan*).

OHIP will not set distribution thresholds or requirements given the need to prioritize member needs and preferences. However, SCNs should monitor and track distribution of referrals to understand from whom members are receiving services and to inform how SCNs can continuously improve.

f. SERVICE RE-AUTHORIZATIONS

i. Overview

As a guiding principle, Enhanced HRSN Services are not intended to be permanent solutions, and Social Care Navigators should work to connect members to more permanent resources (existing federal, state, and local services) where possible.

Six services can be re-authorized beyond the initial 6-month service authorization:

- *2.10 Housing Transition and Navigation*
- *3.1 Nutrition Counseling and Education*
- *3.2 MTM and Clinically Appropriate Meals*
- *3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions*
- *3.4 Pantry Stocking*

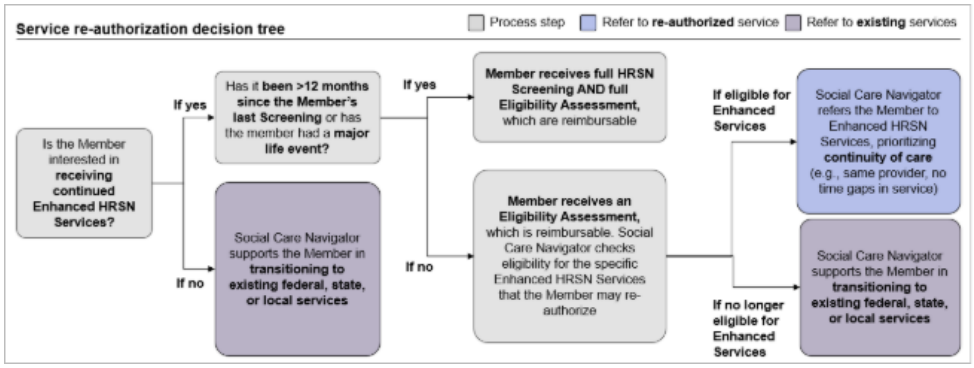
- *4.1 Transportation*

For Enhanced HRSN Services that can be re-authorized, if a member is interested in receiving continued services, a new Eligibility Assessment will need to be conducted (confirming Medicaid eligibility, Enhanced Population, Social Risk Factors, clinical criteria, and duplicative services) and is reimbursable. If a member is determined to be *ineligible* for Enhanced HRSN Services, the member can only be re-assessed within a 12-month timeframe if they experience a major life event, as defined in the Operations Manual "Glossary of Common Terms" (e.g., new symptoms or diagnosis, housing change).

ii. Social Care Navigator workflow for service re-authorization

Social Care Navigators should follow the workflow below to determine if members are interested in continuing service delivery and if so, whether they are eligible to receive additional services. Social Care Navigators should still confirm Medicaid MMC enrollment (via MEVS or ePACES) on the day of the new referral (see Figure 5-5). If the member is determined to be eligible to receive continued Enhanced HRSN Services for any of the above services, then a new referral must be created.

Figure 5-5: Service re-authorization workflow



iii. Additional guidance for re-authorization of Nutrition services

When a Nutrition service requires RDN/CDN approval (as specified in section 5.j.vi), members will need a new nutrition assessment with an RDN/CDN upon re-authorization. As part of the re-authorization for Nutrition services, Social Care Navigators should ensure the following as part of the Eligibility Assessment:

- That the member is actively enrolled in MMC via ePACES/MEVS day of re-authorization
- That the member is still part of Enhanced Population

In addition, Social Care Navigators should ask the following questions and document responses in the Social Care Plan:

1. **Can you prepare and serve adequate meals either by yourself or with the help of a caregiver?**

- If member answers "No" - *refer to MTM or Clinically appropriate meals (based on eligibility criteria)*
- If member answers "Yes" - *Continue to question 2 below*

2. **Would you or a caregiver be able to prepare and serve adequate, nutritious meals if supplied with ingredients and instructions?**
   - If member answers "No" - *Refer to MTM or Clinically appropriate meals (based on eligibility criteria)*
   - If member answers "Yes" - *Refer to food prescription, food vouchers, or pantry stocking (based on eligibility criteria)*

g. ENHANCED SERVICES MEMBER FILE

i. Enhanced Services Member File (ESMF) Overview

The ESMF will be a core data source used in determining members' eligibility for Enhanced HRSN Services. It is a data file referenced during the Eligibility Assessment to identify members who reside within an SCN's region and details their eligibility information. The ESMF will:

- Include all Medicaid Managed Care members
- Identify members who reside in the SCN's region (*see Medicaid Member Eligibility*)
- Assist the SCN in determining member eligibility for Enhanced HRSN Services by identifying eligibility criteria from MCO's member records (e.g., Medicaid High Utilizer, individuals with chronic conditions)
- See Information included in Enhanced Services Member File for the full set of information contained within the Enhanced Services Member File

ii. Process for creating, sharing, and auditing the ESMF

Process by which the ESMF will be created: OHIP will provide a state-prescribed ESMF Template to the MCOs. MCOs will then use the ESMF Template to:

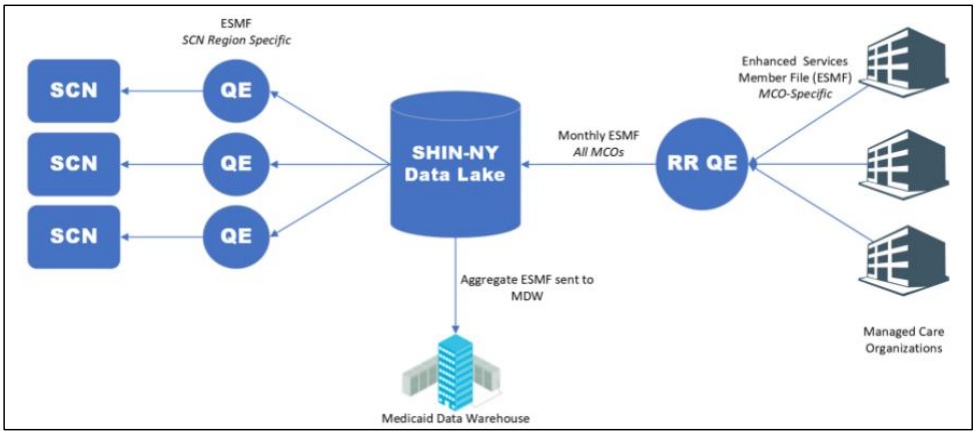
- Create their own algorithm to query all plan members and associated HRSN eligibility criteria
- Populate template with all plan members and their HRSN eligibility information
- Report all plan members, including members with voluntary or involuntary disenrollment

Timing for sharing the ESMF: Refer to the most recent version of the DSIG for time frame MCOs have to transfer the ESMF file to the RRHIO. MCOs will work with the RRHIO to remediate data quality issues by the 4th of the following month. On the 5th of each month, the QEs transfer regional ESMF to each SCN.

Process by which the ESMF will be shared: Once NYeC/SHIN-NY receives the ESMF from MCOs:

- SHIN-NY will send a monthly ESMF to New York State's Medicaid Data Warehouse (MDW)
- The QE partner will obtain the ESMF from the NYeC/SHIN-NY's data lake
- Each SCN's designated QE partner will subsequently send to each SCN an SCN region-specific Enhanced Services Member File
- SCN Lead Entities and MCOs are encouraged to create any additional data sharing agreements they deem appropriate to facilitate this information-sharing

Figure 5-6: Process for sharing of ESMF



Process by which SCNs communicate to MCOs regarding new member information: During the Eligibility Assessment, SCNs may learn new member information that may be relevant to MCOs ~~(i.e., through provider attestation or member documentation)~~per **Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service**. SCN Lead Entities and MCOs will need to work together to establish a process by which SCN Lead Entities communicate this new member information to MCOs.
OHIP will not require MCOs to update their ESMF data with information shared by the SCN Lead Entity.

iii. Information included in the ESMF

The ESMF must include all members enrolled in an MCO regardless of Enhanced Population status. See the latest Enhanced Services Member File Template in the DSIG for the data elements and formatting requirements for the ESMF.

h. CHANGES IN MEMBER MEDICAID COVERAGE AND RELOCATION

It is possible that members may experience changes in Medicaid coverage while receiving Enhanced HRSN Services. OHIP aims to maximize member access to Enhanced HRSN Services while ensuring that members receiving Enhanced HRSN Services are enrolled in a Medicaid Managed Care plan and meet eligibility criteria requirements. The processes below are intended to support continuity of Enhanced HRSN services for members covered by MMC plans in the event of a Medicaid coverage change.

For the purposes of this Manual, “members covered by a MMC plan” refers to all members who are actively enrolled in Mainstream MMC, HIV Special Needs Plans (HIV-SNPS), Health and Recovery Plan (HARP), MLTCP, or MAP.

i. Change in member MMC coverage

If a member experiences a change in Medicaid coverage while they are receiving Enhanced HRSN Services and the member is no longer covered by a MMC plan, SCN Lead Entities should aim to ensure this information is communicated to relevant stakeholders (e.g., member, Social Care Navigator, HRSN service provider) upon notification of the SCN Lead Entity. SCN Lead Entities are responsible for ensuring that delivery of Enhanced HRSN Services to a member end when the member is no longer covered by a MMC plan. OHIP encourages SCNs to support individuals who are not covered by Medicaid to access existing federal, state, or local resources.

Guidance is outlined below regarding (1) members with upcoming potential changes in MMC coverage (e.g., disenrollment from MMC), and (2) members that have experienced a change in MMC coverage.

1. **Guidance regarding members with upcoming potential changes in MMC (e.g., potential upcoming disenrollment from MMC):** Member Medicaid coverage is typically re-verified annually. OHIP recognizes that some members will therefore have to re-verify MMC coverage while receiving Enhanced HRSN Services. SCN Lead Entities should ensure that Social Care Navigators will:

    - *Check MEVS for the latest information during the Eligibility Assessment*: When creating a Social Care Plan, Social Care Navigators should consider the member's upcoming renewal and prospective disenrollment date. For recurring services, the Social Care Navigator MAY (at the discretion of the SCN) refer the member for Enhanced HRSN service delivery only up until the renewal date / prospective disenrollment date, or the maximum service duration end date, whichever comes first
    - *Consider a member's upcoming renewal date:* When authorizing Enhanced HRSN services, Social Care Navigators should consider the member's upcoming MMC renewal date / prospective disenrollment date. Social Care Navigators should make an effort to ensure services are delivered only to members that are enrolled in MMC with expected MMC enrollment through at least expected completion of Enhanced HRSN services (e.g., Home Modifications/Asthma Remediation)
    - *Direct members to existing re-enrollment programs and resources to enable MMC re-enrollment (e.g., Certified Application Counselors, Marketplace Facilitated Enrollers and Social Care Navigators) if the individual has coverage through NY State of Health*: Social Care Navigators and members can find the list of the over 5,550 statewide application assistors on the NY State of Health Website, which enables filtering of assistors by specific areas. For aged, blind and disabled individuals whose eligibility is determined by a local Department of Social Services, a Facilitated Enroller for the Aged, Blind and Disabled can assist in the application process
    - *Social Care Navigators are not required to directly support members with MMC or FFS re-enrollment* (e.g., completing forms)

2. **Guidance regarding members who have experienced a change in MMC coverage:** OHIP expects that most members will be able to re-verify MMC plan coverage. In the case of a change in member eligibility (e.g., member is disenrolled from a MMC plan), SCNs should establish processes consistent with the following OHIP guidance:
    - *Verification of member eligibility in MEVS:* SCNs are required to verify member coverage in MEVS. SCN IT Platforms are required to have integration with the Medicaid Eligibility Verification System (MEVS) in order to verify Medicaid eligibility using one of the MEVS methods. SCNs were provided a deadline of August 31, 2025, for MEVS to be embedded within the SCN IT Platform to enable a direct,

real-time connection to eMedNY. SCN IT Platforms are only required to support the ability to query MEVS to verify a member's Medicaid eligibility at the time of service using a HIPAA-compliant 270/271 transaction.

- *SCN communication expectations:* SCNs are expected to create a process to quickly inform their Network HRSN service providers of changes in coverage of a member receiving Enhanced HRSN Services
- *Delivery of Enhanced HRSN Services:* The SCN Lead Entity and HRSN service providers are responsible for stopping delivery of services to members who are no longer covered by a MMC plan and thus are no longer eligible to receive Enhanced HRSN Services
    - **Home and Safety Modifications / Asthma Remediation:** if a member disenrolls from MMC while their Home Modification or Asthma Remediation is underway, SCNs must end provision of the Home Modifications / Asthma Remediation and return the member's home to serviceable condition. Services should not be provided while the member is not enrolled in MMC
- *Supporting previously enrolled members:* OHIP acknowledges that members who experience a change in Medicaid coverage may need support in finding federal, state, or local resources, reenrolling in Medicaid, or communicating with their HRSN service providers:
    - If a member is disenrolled from MMC and subsequently enrolled in Medicaid FFS, Social Care Navigators will be reimbursed for Navigation supporting members to find existing local, state, and federal resources
    - If a member is disenrolled from Medicaid, a Social Care Navigator *cannot* be reimbursed using waiver funds for providing Navigation services to the individual Social Care Navigators may at their discretion connect individuals to other Navigation resources not supported by waiver funds to access existing federal, state, and local services

ii. Member relocation and change of address

In instances in which a member moves across SCN regions during the course of Enhanced HRSN Service delivery, OHIP aims for the member to experience minimal disruptions in service delivery while transitioning care to a new SCN Lead Entity.

Updating member address: SCNs should proactively instruct members to notify their Social Care Navigator if they are moving or plan to move. If a member's address changes, the process for updating the member's address will proceed as follows:

- Once aware of a member's move, Social Care Navigators communicate address change with relevant MCO(s)
- Additionally, the member's address needs to be updated by LDSS or NYSOH – at whichever entity the member is registered for Medicaid. Social Care Navigators should support MMC members in updating the member address with LDSS or NYSOH in a manner that best suits the member's circumstances and needs and may bill time spent with the member to Enhanced Care Management
    - Social Care Navigators may work with members directly to help them contact LDSS or NYSOH to update their address; OR

- Member can give live verbal consent to LDSS or NYSOH over the phone (e.g., three-way call) that a Social Care Navigator has authorization to speak on their behalf. Live verbal consent from the member is valid for 24 hours
- Social Care Navigators may update member address themselves with LDSS or NYSOH as a member's authorized representative (if a member is interested in receiving this support). To do so, members may submit an authorized representative designation form to LDSS or NYSOH to allow a Social Care Navigator to update an address on the member's behalf. A Social Care Navigator may fill out the authorized representative designation form with input from the member, but must obtain a signature from the member before submitting the form to the relevant entity (LDSS or NYSOH)
- If a member does not know whether they are registered with Medicaid at NYSOH or a LDSS, the member or Social Care Navigator may contact NYSOH at 1-855-355-5777 to determine where the member is registered
- Additional guidance for NYSOH and LDSS is outlined below

- As part of the transition of care, the member's Social Care Navigator in the original region should coordinate with the SCN Social Care Navigator in the member's new region to ensure the member is appropriately re-screened and able to continue receiving needed services as quickly as possible

Table 5-10: Additional guidance for updating member's address

Medicaid enrollment	Additional guidance
NYSOH	• Members or an authorized representative can call the NYSOH Call Center at 1-855-355-5777. Call center agents can speak with a Social Care Navigator directly, with either an authorized representative designation form completed or verbal consent directly from the member that the Social Care Navigator has authorization to speak on their behalf. The member will also need to provide their authentication information • Members can make updates in their online account at nystateofhealth.ny.gov. If members have an enrollment assistor, they can connect with the enrollment assistor directly in their online account to receive assistance • To update an address, the following data is needed: member first/last name, DOB, SSN, CIN, new address, and AC# HX ID
LDSS	• Members or an authorized representative can go in-person or call their LDSS • Eligibility workers at LDSS can speak with a Social Care Navigator directly, with either an authorized representative designation form completed or live verbal attestation directly from the member that the SCN has authorization to speak on their behalf • To update an address, the following data is needed: member first/last name, DOB, SSN, CIN, and new address

Member relocation scenarios

The following section provides guidance for Social Care Navigators on how to approach different scenarios related to member relocation while receiving services.

Member moves permanently *within same SCN region* while receiving Enhanced HRSN services:

- Member-specified residential address should be considered primary address for Enhanced HRSN Services, even if it does not match the address in MEVS / ePACES
- Members may only receive services at one address that is considered their primary home address (with exceptions for minor residing in multiple households)
- Social Care Navigators should document new address in Social Care Plan and initiate the process to update the member's address (as outlined above)

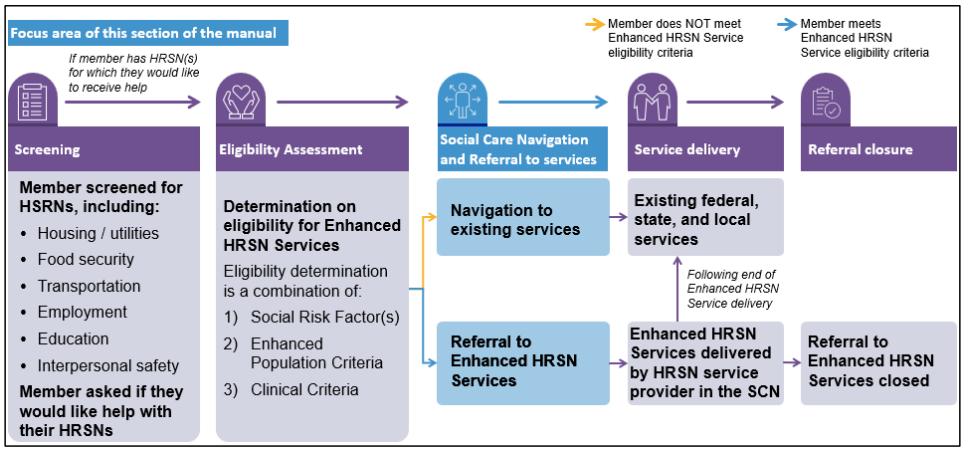
Member moves permanently *to a different SCN region* while receiving Enhanced HRSN services:

- Outgoing Social Care Navigator should initiate communication with the new SCN Lead Entity to discuss the member's Social Care Plan and any urgent needs within 5 business days of becoming aware of the move
- Outgoing Social Care Navigator should support the member to update their address via LDSS or NYSOH (as outlined above)
- Outgoing Social Care Navigator may bill time spent on handover to Enhanced Care Management until member's address is updated in MEVS / ePACES
- All services from outgoing SCN should stop once the member's address registered with Medicaid is updated
- New SCN Lead Entity that is associated where the member lives will need to wait until member's address is updated in MEVS / ePACES or ESMF to initiate referral to new service provider and restart Enhanced HRSN Services if needed

Member is *temporarily* relocating outside their SCN region:

- Members will not be able to temporarily receive services in a different SCN region. Ongoing Enhanced HRSN Services should be temporarily paused while member is away
- Social Care Navigators may refer members to existing federal, state, and local services that may be available during the temporary relocation

i. SOCIAL CARE PLANS



i. Social Care Plan overview

Social Care Plans are individualized member records that help a Social Care Navigator identify a member's unmet HRSNs, develop goals and approaches to address unmet HRSNs, and track progress toward achieving those goals. Per CMS requirements, each member in an Enhanced Services Population will have a Social Care Plan developed by their Social Care Navigator while they are engaged with the SCN program. A member's Social Care Plan will be automatically initiated at the end of the Eligibility Assessment, and the same Social Care Plan should be updated by the Social Care Navigator as needed throughout the duration of the time the member engages the SCN program. The Social Care Plan includes details regarding member assessment and member's HRSNs in order to inform the services and care they receive. Each Social Care Plan will identify the member's unique needs, individualized strategies, and interventions for meeting those needs. Social Care Plans will be completed in collaboration with the member and the member's chosen support network as appropriate in a culturally and linguistically competent way. Social Care Plans will be automatically generated within the SCN IT Platform.

For members belonging to Enhanced Services Population(s), the automation for developing a member's Social Care Plan will be based on the member's answers provided during HRSN Screening and during one-on-one Eligibility Assessments with a Social Care Navigator. The Social Care Plan should be updated as needed by the Social Care Navigator throughout service and with notes helpful to support service coordination by health and social care professionals.

SCN Lead Entities are responsible for ensuring quality and comprehensiveness of Social Care Plans in their Network. Specific processes for oversight and quality review of Social Care Plans may be determined by each SCN Lead Entity. The Social Care Plan is a CMS and DOH requirement. Social Care Plans may be reviewed by OHIP during the program to ensure consistency and comprehensiveness. SCNs do not need to regularly report information on Social Care Plans to OHIP, but OHIP may request to review Social Care Plans at its discretion.

ii. Components of a Social Care Plan

The Social Care Plan is intended to be a living document that demonstrates an eligible member's HRSNs and detail on Enhanced HRSN Services. This form can continually be updated in instances of service renewals, major life events, subsequent annual screens, or if any information is requested to be changed by the member or anyone on their authorized care team. Any specifications for the unmet HRSN should be included in the Social Care Plan as well as justification for the service.

Social Care Plans will only be viewable by the Lead Entity and organizations contracted into the SCN (e.g., HRSN service providers) with approved user roles. HRSN service providers may only view a specific member's Social Care Plan if that HRSN service provider has received a referral to assist the member. HRSN service providers viewing Social Care Plans must have necessary SCN IT Platform User Rights and permissions based on consent received from the member, as determined by the SCN Lead Entity and their SCN IT Vendor, to view a specific member's Social Care Plan.

Social Care Navigators should document in the Social Care Plan all member information learned during interactions with the member that is relevant to the SCN program and provision of Enhanced HRSN services, including information obtained during the Eligibility Assessment.

In developing Social Care Plans, Social Care Navigators should ensure the following sections are included:

- **General member information,** including details on HRSNs that inform care goals and what services are most appropriate for the member
- **Screening and Navigation history,** including how the member was referred to the SCN and assessment notes from other care managers, if relevant
- **HRSN service considerations**, including the member's Eligibility Assessment details that may inform care goals, service provision approach, individual goals, and service delivery information
- **Close of service and member satisfaction,** including details on service delivery outcomes and member experience

A list of components required for inclusion in the Social Care Plan are outlined in *Table 5-11* below. Note the Social Care Plan is not limited to these components and may include additional components at the discretion of the SCN Lead Entity to support service delivery and member experience. Responses to Social Care Plan components may be free text; however, data from Screenings and Eligibility Assessments should be pulled into required fields where applicable.

Table 5-11: Components to include in a Social Care Plan for members in an Enhanced Services Population

Social Care Plan component	Details included in member's Social Care Plan	Auto-populate or Open Field*	Information collected outside Social Care Plan
General member information	Name of Social Care Navigator	Auto-populate	EA
	New address as reported by member (may require updated to NYSOH, LDSS, or coordination with different SCN LE)	Auto-populate	EA Step 2: Confirm the member's identity and their Medicaid enrollment
	Prior Address(es)	Auto-populate	EA Step 2: Confirm the member's

Social Care Plan component	Details included in member's Social Care Plan	Auto-populate or Open Field*	Information collected outside Social Care Plan
			identity and their Medicaid enrollment
	Name of Primary Care Physician	Auto-populate AND Open Field (optional field)	Auto-populate: PCP from ESMF Open Field: If PCP changes or new PCP
	Member's existing Care Team (Health Home, Behavioral Health, SUD providers, etc.)	Open Field (optional field)	No
	Standing care delivery appointments to take into consideration when scheduling additional services or appointments	Open Field (optional field)	No
	Best contact information and preferred method of communication for Social Care Navigator to be in touch with member	Open Field	No
	Name and relationship of members in the household, insurance type, and any relevant Enhanced HRSN services being received - Indicate whether each household member is enrolled in Medicaid	Auto-populate number of household members (optional field) AND Open Field: Names and relationships to member, Medicaid coverage of each household member, services received	EA Step 6: Ask member follow-up questions within the Eligibility Assessment to better understand their unmet HRSNs "How many people are in the member's household?"
	Name and relationship to member of individual who completed the Screening and/or Eligibility Assessment, if it was not the member themselves. If requested, documentation of legally authorized representative should be saved in Social Care Plan regardless of member's age	Auto-populate: Name/Relationship (optional field) Only required for in-person, phone or virtual screenings and EAs done on the IT platform) AND Open Field and upload functionality: supporting documentation if SCN requests	Screening EA
	Additional household and contact information for children age 17 and under that spend considerable amount of time at multiple households. Name of parent or legal guardian, phone numbers and addresses where child spends considerable amount of time	Open Field (optional field)	No
	Current receipt of WIC, SNAP, and TANF	Auto-populate	EA Step 6: Ask member follow-up

Social Care Plan component	Details included in member's Social Care Plan	Auto-populate or Open Field*	Information collected outside Social Care Plan
			questions within the Eligibility Assessment to better understand their unmet HRSNs Follow-up Qs General #1: "Is the member enrolled in TANF (OTDA)? If the member is enrolled in Managed Care and eligible for TANF, the Social Care Navigator can assist with a TANF application." Follow-up Qs Nutrition#1: "Is the member enrolled in SNAP (OTDA) and WIC? If the member is enrolled in Managed Care and eligible for SNAP or WIC, the Social Care Navigator can assist with an application" General: Follow-up question auto-populates TANF, Nutrition: Follow-up questions populate WIC and SNAP
	Barriers to care and additional HRSNs beyond what is identified in the tool, for example challenges getting children to school or getting to work, disabilities	Auto-populate	EA Step 6: Ask member follow-up questions within the Eligibility Assessment to better understand their unmet HRSNs Follow-up Questions
	Upcoming member MMC renewal date / prospective disenrollment date, and plan to support member leading up to their renewal	Auto-populate AND	Auto-populate: Prospective

Social Care Plan component	Details included in member's Social Care Plan	Auto-populate or Open Field*	Information collected outside Social Care Plan
		Open Field for renewal date and plan to support member leading up to renewal date	enrollment date from ESMF
Screening and Navigation history	Referring entity to SCN (if applicable)	Auto-populate	Screening
	Major life events requiring a Re-screening	Dropdown of MLE options and ability to select more than 1	No
	Service coordination history (e.g., dates of assessments, names of case managers, and providers)	Auto-populate	Screening EA
	Service coordination notes, outreach attempts & updates from approved user roles (e.g., updates from MCO care managers, HRSN service providers)	Functionality should appear as a contact log to allow for rolling comments and replies that include date and free text space within the comment field. Must allow generation of downloadable PDF	No
	Eligibility Assessment notes (e.g., documentation, existing federal services received) from approved user roles (e. g health and social care professionals)	Open Field	No
HRSN Service Considerations	Eligibility criteria (Enhanced Population criteria clinical criteria, Social Risk Factors) Refer to Table 5-16 "Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service" in SCN Operations manual for all forms of acceptable documentation	Auto-populate AND Ability to upload or input documentation	EA Step 5: Check whether the member is included in an Enhanced Population EA Step 7: Confirm the member's eligibility for Enhanced HRSN Services, including confirming Social Risk Factors and ensuring there is no service duplication
	Enhanced HRSN services for which the member is eligible	Auto-populate	EA Step 7: Confirm the member's eligibility for Enhanced HRSN Services, including confirming Social Risk Factors and ensuring there is no service duplication

Social Care Plan component	Details included in member's Social Care Plan	Auto-populate or Open Field*	Information collected outside Social Care Plan
	Detailed considerations for any service a member may receive, including: • Nutrition considerations (e.g., dietary restrictions, risk of food insecurity) • Housing considerations (e.g., unsheltered or unhoused status, existing residential or care setting) • Transportation needs (e.g., distance, preference based on HRSN service the member is seeking)	Auto-populate: Existing information across the domains related only to a member's unmet needs AND Open Field: Any additional insights from the Navigator	EA Step 6: Ask member follow-up questions within the Eligibility Assessment to better understand their unmet HRSNs
	Details on completed and open HRSN referrals (e.g., specific organization, frequency, start / end dates, etc.)	Auto-populate	Referral: Include all completed and open referrals for historical purposes
	Re-authorization of services if applicable and member remains eligible (e.g., additional six months of Medically Tailored Meals) • For Nutrition service referrals for groceries or meals, re-confirm answers to EA Step 6: Questions 1 and 2	Open Field (optional field)	No
	Disenrollment and/or denial of service details	Auto-populate: Disenrollment AND Open Field (Denial of Service Details)	EA Step 8: Confirm that the Medicaid Managed Care member wants to receive Enhanced HRSN Services for which they are eligible and inform member of potential COI, if relevant
	Goals for the member to address their HRSNs	Open Field	No
	Confirmation from SCN Lead Entity or Social Care Navigator that Freedom of Choice was verbally provided to the member during the Eligibility Assessment	Auto-populate	EA Step 8: Confirm that the Medicaid Managed Care member wants to receive Enhanced HRSN Services for which they are eligible and inform member of potential COI, if relevant
Close of service and member satisfaction	Progress on member goals (e.g., meeting member goals using SNOMED Goal codes)	Auto-populate dropdown of applicable SNOMED Goals based on unmet needs	No
	Notes on member experience with services	Open Field	No

**Note: Both open and auto-populated fields should allow Social Care Navigator to edit and expand upon the topic in order to document additional details collected during the discussion with the member*

Person-Centered Goal Setting: Social Care Plans must include goals identified by the Social Care Navigator and member to address member needs. SNOMED-CT codes for Person-Centered Goals Setting can be mapped to goals in the Social Care Plan. Person-Centered Goal Setting codes are encouraged to be used in Year 1 but not required until Year 3. For details on the relevant SNOMED-CT Codes, please reference the NYeC Extranet to view the latest Excel.

Updating the Social Care Plan: Social Care Navigators should continually update the living Social Care Plan to maintain up-to-date information on a member's HRSNs and services and track progress toward goals. The Social Care Plan should be updated at least annually and whenever a member:

- Undergoes an Eligibility Assessment
- Engages with the Social Care Navigator
- Experiences a major life event (e.g., significant change in housing, serious injury, inpatient hospital admittance)
  Has a change in their needs and/or services (e.g., member Social Care Plan goal is met, member receives services)

Coordinating with existing care plans: For all members in an Enhanced Population, SCNs are expected to ensure Social Care Plans are distinct and separate from existing care plans covering clinical care, which is outside the scope of SCNs. If the Social Care Navigator has access to an existing care plan for a member (e.g., a Health Home care plan) that includes these details already, then these additional details do not need to be duplicated in the Social Care Plan as long as this information is appropriately documented in the SCN IT Platform.

iii. Considerations for children and youth

As for all eligible members, SCNs are expected to develop comprehensive Social Care Plans for children to inform the details of the Enhanced HRSN services required to best address each eligible member's unmet HRSNs.

Children with support of their parent, guardian, or legally authorized representative are encouraged to contribute to discussions with their Social Care Navigator during development of their Social Care Plan.

Additional details to include in Social Care Plans for children and youth: Social Care Plans for children and youth should include all the details described above, as well as:

- Household composition, including any other children in the household
- Identification of which household members are receiving Medicaid
- Identification of whether the child receives free or reduced priced school meals, if applicable, provided through the National School Lunch Program
- Name and relationship of individual completing the Screen on the member's behalf
- The school the child attends
- Whether they receive childcare outside of the home, and if so where
- Enrollment in Early Intervention services, school-based services, or other services for developmental, speech, or learning issues

- Enrollment in programs such as Health Homes Serving Children; and
- Services received within the Office for People with Developmental Disabilities programs or Office of Mental Health

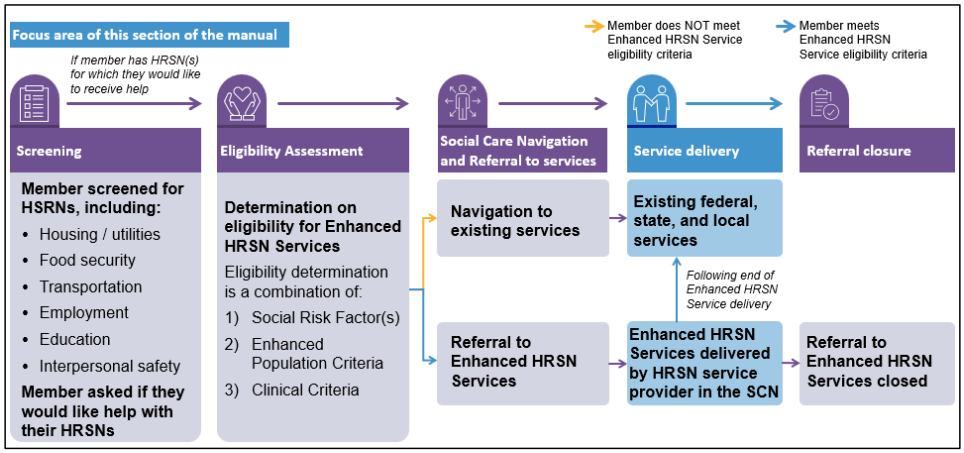
iv. IT Platform functionality to enable Social Care Plans

Social Care Plans must be stored in the SCN IT Platform. The SCN IT Platform will be required to automatically generate and save a member profile that includes the Social Care Plan for each member. The SCN IT Platform must be able to:

- Store information about each member
- Allow for updates on an ongoing basis
- Store documents and notes collected by Social Care Navigators (e.g., provider attestation email, verbal consents, or forms for Eligibility Assessments, notes from ongoing meetings with members, member attestation documentation)
- Store documents and notes collected by HRSN service providers (e.g., notes from ongoing meetings with members, member documentation)

Social Care Plan data should be extractable from one location and automatically pull all needed fields into a single, viewable document form which could be printed and made available upon request to a member or anyone in a member's authorized care team (e.g., a PDF report, single member page on IT Platform). Note that Social Care Plans should be auditable.

j. HRSN SERVICES



i. Introduction to member eligibility and medical appropriateness

OHIP has defined evidence-based Enhanced HRSN Services that may be delivered by the SCN and reimbursed by OHIP for the Enhanced Population. These Enhanced HRSN Services and associated eligibility criteria will be posted on both the OHIP website and on the regional SCN websites. The following Enhanced HRSN Services will be available in every region throughout NYS and will span the following social need domains: Care Management, Housing, Nutrition, and Transportation.

A majority of the Enhanced HRSN Services may be reimbursed for up to six months. Medically tailored meals and clinically appropriate meals are able to be reimbursed for an additional six months if the SCN determines that the individual still meets the clinical and needs-based criteria. Select Nutrition services may be reimbursed for up to 11 months for specific populations. Other services are limited as noted below.

Social Care Navigators may consider the member's upcoming renewal / prospective disenrollment date in making determinations related to Enhanced HRSN Service delivery. For recurring services (e.g., services that require more than a one-time delivery), the Social Care Navigator MAY (at the discretion of the SCN) refer the member for Enhanced HRSN service delivery only up until the renewal date / prospective disenrollment date, whichever comes first.

In addition to helping to navigate Medicaid members to the most appropriate HRSN services, Social Care Navigators will help ensure HRSN services are delivered in a manner that sufficiently address the needs of the member. SCN Lead Entities will be accountable for ensuring that Networks have sufficient capacity to provide Enhanced HRSN Services to address eligible member demand in the region.

OHIP intends for the SCNs to bridge members engaged with the following Enhanced HRSN Service domains listed in this section (Care Management, Housing, Nutrition, Transportation) to existing local, state, or federal services 60 days prior to the Enhanced HRSN Service duration ending, to the extent possible.

To be eligible for the Enhanced HRSN Services and to ensure the services are medically appropriate, OHIP will require that an individual identified as needing Enhanced HRSN Services meet the following clinical and social risk criteria as determined through the Eligibility Assessment:

Table 5-12: Clinical and Social Risk Criteria determined through the Eligibility Assessment

Component number	Component of eligibility determination[a]	Description	Source
1	Unmet HRSNs	Member must **have an identified unmet HRSN(s)** per the AHC HRSN Screening Tool Member must be assessed to **meet related Social Risk Factor descriptions**, detailed below	HRSN Screening, Eligibility Assessment[b]
2	Enhanced Population	Member must **belong to one or more covered populations**, as assessed by criteria detailed below	Eligibility Assessment

3	Clinical Criteria / Social Risk Factors	Member must **demonstrate medical necessity for individual Enhanced Services**, as assessed by clinical criteria / Social Risk Factors detailed per service type below	Eligibility Assessment
4	Not receiving duplicative services[c]	Member must be assessed by Social Care Navigator as **not receiving duplicative services**, including but not limited to existing waivers and ILOS provided by MCOs	Eligibility Assessment

a. Member must meet all components 1-4 of eligibility determination to receive Enhanced Service(s)
b. Confirmation of unmet HRSNs in Eligibility Assessment will occur during 1-1 conversation between member and Social Care Navigator, in the instances in which entity doing Screening is also not doing Navigation
c. Determination of what services count as "duplicative" will be made by the SCN based on OHIP guidance

OHIP will maintain the clinical and social risk criteria detailed above on a public-facing webpage. The content will be updated if the criteria is changed, and members will need to meet any other criteria as set forth in future versions of the operations manual. In the event that eligibility criteria for Enhanced HRSN Services change over the course of this program, members already receiving services will not have their services interrupted. The member does not need to be reassessed to meet new criteria in order to receive services. However, once service delivery is complete (e.g., at the end of 6 months), the member must meet the new eligibility criteria, as determined in an additional Eligibility Assessment, in order to receive additional services.

ii. Enhanced Populations

Table 5-13 describes the enhanced populations that will be eligible to receive Enhanced HRSN Services, provided they also satisfy the applicable Social Risk Factors and clinical criteria and the Enhanced HRSN Services are determined to be medically appropriate.

Expectations for validation of clinical criteria, if any (i.e., for which criteria documentation will be required if included in Enhanced Services Member File) will be shared at a later date.

Table 5-13: Enhanced Population Descriptions

Enhanced Population	Population Description
Medicaid High Utilizer (adults and children)	Individuals with… • Five or more Emergency Department visits within the last 12 months; or • Four or more Emergency Department visits and one or more Hospital inpatient stays within the last 12 months; or • Two or more Hospital inpatient stays within the last 12 months • Admission or discharge from an acute care hospitalization related to a health condition or illness, as a qualifying condition for Medical Respite Service Only

Enhanced Population	Population Description
Enrolled in a NYS Health Home (adults and children)	Individuals enrolled in a NYS designated Health Home that currently includes individuals with HIV/AIDS, Serious Mental Illness, Serious Emotional Disturbance, Complex Trauma, Sickle Cell Disease, or two or more chronic conditions (such as, diabetes, congestive heart failure (CHF), chronic kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma or Substance Use Disorder (SUD)). Medicaid Health Homes - Comprehensive Care Management (ny.gov)
Individuals with Substance Use Disorder (SUD)	Individuals diagnosed with a Substance Use Disorder
Individuals with Serious Mental Illness (SMI)	Individuals with a persistent, disabling, progressive or life-threatening mental health condition that requires treatment and/or supports in order to be stabilized, prevent the condition from worsening, or maintain health goals. It includes those with a mental health diagnosis, such as schizophrenia, bipolar disorder, as well as those at-risk of suicide.
Individuals with Intellectual and Developmental Disability (IDD) (adults and children)	Individuals with an Intellectual Disability or Developmental Disability (I/DD) that requires services or supports to achieve and maintain care goals. Includes a diagnosis of an Intellectual or Developmental Disability, including Autism Spectrum Disorder, Cerebral Palsy, Intellectual Disability, or a genetic condition related to I/DD such as Prader-Willis syndrome, Down syndrome, Angelman syndrome, Fragile X syndrome, Williams syndrome, Rett syndrome, Klinefelter syndrome, other childhood disintegrative disorder, other pervasive developmental disorders, pervasive developmental disorders, Phenylketonuria, Dravet syndrome, Fetal Alcohol Syndrome.
Pregnant and Postpartum Persons	Pregnant and up to 12 months postpartum.
Post-Release Criminal Justice-Involved Population with chronic conditions, SUD, or chronic Hepatitis-C	Individuals who are up to 90 days post-release from incarceration and have a chronic condition[1], Substance Use Disorder or hepatitis C.
High Risk Children under the Age of 18	Individuals under 18 who have at least one of the following: • A chronic condition, (e.g., mental health condition, developmental delay, chronic life-threatening allergies, physical disability, and asthma); • Overweight, obese, or underweight as a qualifying condition for nutrition interventions only;

[1] A full list of Eligible Chronic Conditions can be found here: Health Home Chronic Conditions (ny.gov)

Enhanced Population	Population Description
	• Malnutrition or at-risk of developmental or growth delay or impairment as a result of insufficient nutrition as a qualifying condition for nutrition interventions only; • Child maltreatment as defined by the CDC; • Is a child with a special health care need (CYSHCN) as defined by HRSA; • Low birth weight of <2500 grams; • A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect

iii. Social Risk Factors

After being determined to be a part of an Enhanced Population, members are assessed by their Social Care Navigator for Social Risk Factors. For each identified unmet HRSN from member's Screening results, the Social Care Navigator must assess the related Social Risk Factor (*Table 5-14*).

Table 5-14: Social Risk Factors

AHC HRSN Screening Tool Question and Related Unmet Need Response	Risk factor	Risk Factor Description
Housing: *What is your living situation today?* • I have a place to live today, but I am worried about losing it in the future • I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	Housing related need	An individual who: Is homeless or at-risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5), except for the annual income requirement in 24 CFR 91.5 (1)(i)). Requires a clinically appropriate Home Modification / Remediation service. Resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, and/or refrigeration unit for medications or breast milk is clinically appropriate as a component of health services treatment or prevention.

AHC HRSN Screening Tool Question and Related Unmet Need Response	Risk factor	Risk Factor Description
Housing: *Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY* • Pests such as bugs, ants, or mice • Mold • Lead paint or pipes • Lack of heat • Oven or stove not working • Smoke detectors missing or not working • Water leaks	Housing related need	An individual who: Requires a clinically appropriate Home Modification / Remediation service. Has a health condition that is exacerbated by the individuals physical living environment.
Housing: *In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?* • Yes • Already shut off	Housing-related need	An individual who is homeless or at-risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)).
Nutrition: *Within the past 12 months, you worried that your food would run out before you got money to buy more.* • Often true • Sometimes true	Nutrition-related need	An individual who screens "Often true" or "Sometimes true" to the Nutrition questions on the AHC HRSN Screening Tool and meets the USDA definition of low food security in which the individual reports reduced quality, variety, or desirability of diet; little or no indication of reduced food intake; or very low food security in which the person reports multiple indications of disrupted eating patterns and reduced food intake.
Nutrition: *Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.* • Often true • Sometimes true	Nutrition-related need	An individual who screens "Often true" or "Sometimes true" to the Nutrition questions on the AHC HRSN Screening Tool and meets the USDA definition of low food security in which the individual reports reduced quality, variety, or desirability of diet; little or no indication of reduced food intake; or very low food security in which the person reports multiple indications of disrupted eating patterns and reduced food intake.

AHC HRSN Screening Tool Question and Related Unmet Need Response	Risk factor	Risk Factor Description
Transportation: *In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?* • Yes	Transportation-related need	An individual who screens as having a transportation deficiency and is unable to get to HRSN services without assistance. Having an unmet need includes, but is not limited to: • Not having a valid driver's license; • Not having a working vehicle available in the household; • Being unable to travel or wait for services alone; or • Having a physical, cognitive, mental, or developmental limitation

iv. Eligibility by service

Eligibility for Enhanced HRSN Services will be determined based on Enhanced Population, Social Risk Factors and Clinical Criteria provided on the ESMF -per **Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service**, and consideration of any potentially duplicative services *(Table 5-15)*.

Table 5-15: Eligibility for each Enhanced HRSN Service based on Enhanced Population, Social Risk Factors, Clinical Criteria, and Potentially Duplicative Services

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
1) Care Management				
1.1 Navigation	All Medicaid members with identified unmet HRSN	Enrolled in Medicaid and screens as having an unmet need using the AHC HRSN Screening Tool	N/A	N/A
1.2a Enhanced HRSN Care Management – Eligibility Assessment Level 2 Only	All Enhanced Populations	Enrolled in Medicaid Managed Care and screens as having an unmet need using the AHC HRSN Screening Tool	Enhanced Population	N/A

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
1.2b Enhanced HRSN Care Management – Care Management Level 2 Only				
2) Housing				
2.1 Medically necessary Home Accessibility and Safety Modifications: Ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Is determined to have a need for modification and remediation services to increase and/or improve home accessibility and safety by a Social Care Navigator	• Physical disability that limits independence; and • Documentation from member's provider attesting to medical necessity *(see* **Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service** ~~*provider attestation form*~~*)*	• OPWDD Waiver • TBI Waiver • NHTD Waiver • Children's Waiver • Medicaid Advantage Program • MLTCP
2.2a Medically necessary Home Remediation Service: mold / pest remediation	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Requires a clinically appropriate Home Modification/Remediation service	Has a health condition or is at-risk for a health condition that is exacerbated by the individual's physical living environment and; • Documentation ~~from member's provider~~ attesting to medical necessity *(see* **Table 5-16: Eligibility determination pathways for each Enhanced Population and**	• Medicaid Advantage Program • MLTCP

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
			Enhanced HRSN Service~~*provider attestation form*~~*)*	
2.2b Medically necessary Home Remediation Service: ~~repairing or improving~~ Ventilation Improving Systems including air conditioners, heaters, humidifiers, dehumidifier	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Requires a clinically appropriate Home Modification/Remediation service; and Resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, and/or refrigeration unit for medications or breast milk is clinically appropriate as a component of health services treatment or prevention	• Chronic condition (such as diabetes, congestive heart failure (CHF), chronic kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS) • Previous heat-related illness (heat stroke, heat exhaustion, heat syncope, Rhabdomyolysis, heat cramps, or heat rash) requiring emergency room or urgent care visit, within the last 12 months that occurred at home • Previous cold-related illness (hypothermia, frostbite, trench foot, or chilblains) requiring emergency room or urgent care visit within last 12 months that occurred at home • Individuals regularly taking medications or have an otherwise stated condition that interferes with daily thermoregulation	• Medicaid Advantage Program • MLTCP

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
2.2c Medically necessary Home Remediation Service: refrigeration units as needed for medical treatment	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities and/or nutrition domain; and Resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, and/or refrigeration unit for medications or breast milk is clinically appropriate as a component of health services treatment or prevention	• Prescribed medication requiring refrigeration for the management of a chronic condition • Pregnant and postpartum persons that require refrigeration for breast milk • Enteral and parenteral nutrition	• Medicaid Advantage Program • MLTCP
2.3 Asthma Remediation	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Requires a clinically appropriate Home Modification/Remediation service; and Has a health condition that is exacerbated by the individual's physical living environment	An individual who is diagnosed with asthma, and at least one of the following: • One or more hospital inpatient stays(s) related to asthma within the last 12 months; or • Two or more ED visits related to asthma within last 12 months; or • Three or more urgent care visits related to asthma within the last 12 months; or • Two or more prescribing events for oral steroid use related to an asthma diagnosis within the last 12 months; or • Three to eleven prescribing events for a rescue inhaler, including albuterol within the last 12 months	• Healthy Homes • Medicaid Advantage Program • MLTCP

Service	**Eligible Population**	**Social Risk Factors**	**Clinical Criteria**	**Potential Duplicative Services** (with accompanying fields in ESMF)
2.4 (Recuperative Care) Medical Respite – Pre-Procedure and Post-Hospitalization	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Individual is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	<u>Pre-procedure</u>: • Requiring pre-surgical or pre-procedure care as indicated by a medical professional Post-hospitalization: • Transitioning from an institution or Acute care hospitalization related to a health condition or illness; and • Requiring recuperation and care for an illness or injury; and • At-risk for incurring other Medicaid state plan services, such as inpatient hospitalization or Emergency Department visits	N/A
2.5 Rent / Temporary Housing (Rental Subsidy and Back Rent) for up to six months	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Individual is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	An individual who is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i), including those that have, but not limited to: • Individuals who have a chronic condition, including mental health conditions and physical disability and transitioned out of institutional care / congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs,	N/A

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
			correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals within the past 90 days; or • Youth transitioning out of the child welfare system including foster care	
2.6 Utility Setup / Assistance	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Receiving Rent / Temporary Housing (Rental Subsidy and Back Rent) for up to 6 months	An individual who is homeless or at-risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i), including those that have, but not limited to: • Individuals who have a chronic condition, including mental health conditions and physical disability and transitioned out of institutional care / congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals within the past 90 days; or • Youth transitioning out of the child welfare system including foster care	N/A

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
2.7 Pre-Tenancy Services	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Individual is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	Enhanced Population	N/A
2.8 Community Transitional Supports	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Individual is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	Enhanced Population	• OPWDD Waiver for those moving out of an institutional or other provider-operated setting • TBI Waiver • NHTD Waiver • Medicaid Advantage Program • MLTCP
2.9 Tenancy Sustaining Services	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Individual is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for	Enhanced Population	N/A

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
		the annual income requirement in 24 CFR 91.5 (1)(i)		
2.10 Housing Transition and Navigation Services	All Enhanced Populations	Assessed to have unmet HRSN(s) under housing / utilities domain; and Individual is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	Enhanced Population	• Medicaid Advantage Program • MLTCP
3) Nutrition				
3.1 Nutrition Counseling and Education	All Enhanced Populations	Assessed to have unmet HRSN(s) under food security domain; and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC HRSN Screening Tool	Enhanced Population	• Nutritional Counseling • NHTD Waiver
3.2a Medically Tailored Meals	All Enhanced Populations	Assessed to have unmet HRSN(s) under food security domain; and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN	• Any Chronic condition indication listed on the ESMF (per clinical criteria accepted by Health Homes) such as diabetes, congestive heart failure (CHF), chronic kidney disease, chronic	• MTM ILOS • NHTD Waiver

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
		need under food security domain per AHC HRSN Screening Tool	obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS), OR • Pregnant and postpartum persons OR • Enhanced Population eligibility for: ○ Health Home enrollment on "EPOP_HHENROLLED", "EPOP_IDD" ○ SUD or SMI within the "EPOP_Other" field ○ I/DD within the "EPOP_IDD" field	
3.2b Clinically Appropriate Home Delivered Meals	All Enhanced Populations	Assessed to have unmet HRSN(s) under food security domain; and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC HRSN Screening Tool	Enhanced Population	• MTM ILOS • NHTD Waiver
3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	All Enhanced Populations	Assessed to have unmet HRSN(s) under food security domain; and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC HRSN Screening Tool	Enhanced Population	N/A

Service	Eligible Population	Social Risk Factors	Clinical Criteria	**Potential Duplicative Services** (with accompanying fields in ESMF)
3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	• Pregnant and postpartum persons • High-risk children under the age of 18	Assessed to have unmet HRSN(s) under food security domain; and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC HRSN Screening Tool	• Pregnant and postpartum persons • High-risk children under the age of 18	N/A
3.5 Cooking Supplies	All Enhanced Populations	Assessed to have unmet HRSN(s) under food security domain; and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC HRSN Screening Tool	Enhanced Population	N/A
4) Transportation Services				
4.1 Transportation related to HRSN service or care management	All Enhanced Populations	Assessed to have unmet HRSN(s) under transportation and needs transportation assistance to assess HRSN and/or care management activities. An unmet need includes, but is not limited to: • Not having a valid driver's license; • Not having a working vehicle available in the household; • Being unable to travel or wait for services alone; or having a physical, cognitive,	Enhanced Population	• OPWDD Waiver • TBI Waiver • NHTD Waiver • Children's Waiver

Service	Eligible Population	Social Risk Factors	Clinical Criteria	Potential Duplicative Services (with accompanying fields in ESMF)
		mental, or developmental limitation		

v. Criteria for documentation and attestation

A key required step of the Eligibility Assessment is the Social Care Navigator confirming the member's eligibility for Enhanced HRSN Services. Most criteria related to eligibility (both the Enhanced Population criteria and clinical criteria associated with specific Enhanced HRSN Services) will be shared with SCNs through the Enhanced Services Member File (ESMF) (*see Eligibility Assessment Process and ESMF for more details*). However, there may be circumstances in which the Social Care Navigator must use additional information beyond the ESMF to determine a member's eligibility for Enhanced HRSN Services.

Circumstances in which a Social Care Navigator needs to use sources in addition to the ESMF:

- *Criteria that are not included in the ESMF*: There are a handful of criteria for which the ESMF will not provide information about the member (e.g., homelessness). For these criteria, the Social Care Navigator will need to ask the member to self-disclose this information in order to determine eligibility for Enhanced HRSN Services
- *ESMF information is not fully up to date*: Because the ESMF is based on historical claims data, there may be situations in which a member informs the Social Care Navigator of more up-to-date information than is included in the ESMF (for example if the member is pregnant, but that information is not yet reflected in the ESMF). The Social Care Navigator may learn this information during engagement with a member

OHIP has outlined different sources that may be used to validate each criterion (*see details in Table 5-16*). OHIP's goal is to maximize member access to Enhanced HRSN Services by creating multiple pathways for eligibility validation while also ensuring services are provided to eligible members. The process for attestation is intended to minimize burden on members, HCPs, and Social Care Navigators, while ensuring that member's eligibility determination for Enhanced HRSN Services is within the appropriate remit of each stakeholder (e.g., the Social Care Navigator cannot make clinical decisions, care managers cannot make clinical diagnoses but can review the member's health records, etc.).

Who can attest:

- **MCOs and Health Homes** can provide a verbal attestation, a HIPAA compliant written email attestation, physical provider attestation form, or through care coordination notes in SCN IT Platform, if not otherwise directly supplied by the ESMF. As a best practice, SCNs should utilize the verbal attestation or email attestation process with the MCO or Health Home (when applicable) instead of through other methodologies
- **Health care providers (HCPs)** and other entity types listed below can either provide a HIPAA complaint written email attestation OR complete the physical provider attestation form. If a Social Care Navigator

is unable to find a provider who meets the criteria below to attest on behalf of a member because a member has been treated by providers outside of NYS, SCN Lead Entities should reach out to their OHIP contract manager to discuss options

- **NYS licensed health care provider that accepts Medicaid members.** NYS licensed health care providers are limited to: Physicians, Midwives (MW), Nurse Practitioners (NP), Nurses (LPN, RN), Doulas (Perinatal, Group), Physician Assistants, Clinical Psychologists, Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists, and Licensed Mental Health Counselors (LMHC)
- **Other health care providers** that are part of programs within larger agencies that accept Medicaid members (e.g., Health Home, School-based Health Centers, Care Management agencies) and with access to necessary clinical information (e.g., member's relevant medical records)

- **Members** can provide verbal attestation or written documentation for select Enhanced HRSN Services where permitted within Table 5-16

Member documentation is permitted for select Enhanced HRSN services per Table 5-16, the Social Care Navigator should work with the member to develop a plan for how the member will obtain and submit required documentation. The Social Care Navigator's support and planning should include:

- Sharing acceptable forms of documentation with the member.
- Member name and DOB
- Member Client Identification Number (optional)

Member attestation is permitted for select Enhanced HRSN services per table 5-16, Social Care Navigators will ask members to provide verbal attestation to the criterion that must be documented by the Social Care Navigator in the SCN IT Platform (e.g., via a checkmark confirmation in the SCN IT Platform). When completing member attestation, Social Care Navigators may rely on the following script (outlined below) for criteria relevant to the member and their potential unmet HRSN.

SCNs should integrate this member attestation confirmation capability into their IT Platforms. Social Care Navigators are required to document a "Yes" answer to any of the questions below, if asked.

Script for Social Care Navigators: Tell member: *Please answer the following questions with a "yes" or "no" answer:*

- **Pregnancy and Postpartum Status:**
  - **Ask member:** *Are you currently pregnant or up to 12 months postpartum?*
- **If pregnant or postpartum and interested in refrigeration units as part of medically necessary Home Modifications:**
  - **Ask member:** *Do you require refrigeration for storage of breast milk?*
- **Physical disability that limits independence:** *as part of the criterion for medically necessary Home Modifications (note: this service requires an attestation)*
  - **Ask member:** *Do you currently have a physical disability that limits independence in your home, such as difficulty walking or temporary paralysis?*
- **Heat or cold-related Illness: for the "at-home" criterion needed for medically necessary Home Modifications, including medically necessary air conditioners, heaters, humidifiers, dehumidifiers**

- **Ask member:** *Have you experienced a heat-related illness (such as heat stroke, heat exhaustion, heat syncope, Rhabdomyolysis, heat cramps, or heat rash) that required an emergency room or urgent care visit within the last 12 months and occurred at home?*
- **Ask member:** *Have you experienced a cold-related illness (such as hypothermia, frostbite, trench foot, or chilblains) that required an emergency room or urgent care visit within the last 12 months and occurred at home?*

Social Care Navigator workflow to collect provider attestation:

The Social Care Navigator must ensure all forms of attestations are documented or uploaded into the member's Social Care Plan or Member's Profile. Attestations are valid for 12 months from dated written attestation (i.e., physical form, email, care coordination notes, member documentation) or from date of received verbal attestation. Sources for Social Care Navigators to validate member eligibility to receive Enhanced HRSN Services outside of the ESMF include the options below. As best practice, Social Care Navigators should first rely on the MCO's or Health Home's verbal or email attestation where indicated before utilizing a physical provider attestation form.

- **Verbal attestations** are permitted ONLY from MCOs and Health Home providers. When a member is enrolled in a Health Home, Navigators should first reach out to the Health Home for assistance. All verbal attestations must meet the SCN LE's HIPAA requirements. MCOs and Health Home providers should review the criteria on the provider attestation form to verify the appropriate member diagnosis or condition for HRSN services. MCOs and Health Homes must include the below information in verbal attestations and Navigator's should save the dated response within the IT Platform.
  - Member name and DOB
  - Member Client Identification Number (optional)
  - Entity name
  - MCO or Health Home name
  - Member eligibility criteria being attested to
  - Maternal or Child Health PHI disclosures (if applicable)
- **HIPAA compliant email attestations** are permitted from HCPs, MCOs, Health Homes and other entity types listed on the physical provider attestation form. Providers should review the criteria on the provider attestation form to verify the appropriate member diagnosis or condition for HRSN services. The email should include the below information:
  - Member name and DOB
  - Member Client Identification Number (optional)
  - Entity name
  - Facility name (i.e., MCO, Health Home, HCP business name)
  - Provider NPI
  - Medicaid Provider ID (MMIS) Number (if no NPI)
  - Member eligibility criteria being attested to
  - Maternal or Child Health PHI disclosures *(if applicable)*

A provider attestation form has been created by OHIP to streamline the attestation process for Providers, Social Care Navigators, and members. The provider attestation form can be found on the following website: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/providers.htm.

If the Social Care Navigator determines that provider attestation is needed in order to support member eligibility, the Social Care Navigator can request and receive provider attestation by either (1) the provider submitting the OHIP standard attestation form directly to the Social Care Navigator through HIPAA compliant transmission methods; OR (2) a member submitting the OHIP standard attestation form on behalf of their provider to the Social Care Navigator. The provider attestation form can be simplified to clarify that a provider only has to review and attest to select eligibility criteria that will support the member's unmet need and eligibility for select services.

The Social Care Navigator should work with the member to develop a plan for how the provider attestation form will be completed and collected. The Social Care Navigator's support and planning should include:

- Discussing with the member options for outreach to the provider with form and completion details
- Providing guidance for how the provider can submit the documentation to the Social Care Navigator through a HIPAA compliant transmission method
- Conducting outreach and follow-up, as needed to the member and/or provider to check on the status of the documentation. Social Care Navigators are encouraged to work with health care providers to communicate relevant member information (e.g., unmet HRSN) when requesting provider attestation

Provider attestation forms must be returned to SCN Lead Entities or any other HIPAA covered entities within the SCN. The completed provider attestation form and the Provider's individual National Provider Identifier (NPI) must be stored on the SCN IT Platform. If the Individual NPI is not available, then the Medicaid Provider ID (MMIS Number) may be collected

If the health care provider is attesting to any criteria included in the "Maternal or Child health" section of the provider attestation form (e.g., pregnant or postpartum criteria) and sharing back with the SCN, the SCN must provide to the health care provider a signed form regarding the disclosure of protected health information. The SCN should sign and provide this form to the health care provider along with the attestation form. Per Table 5-16 below, it is important to note that Social Care Navigators are allowed to accept a member's verbal attestation to their own status of being pregnant or post-partum without the need for requiring a provider attestation.

OHIP provider attestation guidance includes both forms:

- Form for providers to attest to eligibility criteria
- Form for SCNs to attest regarding the disclosure of Protected Health Information (PHI)

Provider guidance:

1. NYS licensed health care providers will need to attest that:

- They are providing an attestation for enhanced populations or clinical criteria within their scope of authorized practice under state law; OR
- They have sufficient access to information (e.g., electronic health record) pertaining to the clinical criteria/Enhanced Population.

2. Other health care providers that are part of programs within larger agencies that accept Medicaid members will need to attest that:

- They have reviewed documentation from a licensed Medicaid-enrolled provider per eMedNY and can attest to the member meeting specified eligibility criteria.

If a health care provider at a rehabilitation center completes the provider attestation form or attestation email, the rehabilitation center may need to coordinate with the member to obtain any necessary HIPAA release permission / documentation to be able to share the form back with the SCN.

Table 5-16: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service

Note on the table below: *Criteria for which attestation and/or documentation may be used are subject to change. As indicated on the below table, a "Yes" means any of the single methods can be used independently and should be read as "or". An indication of "Yes" does not mean that all methods need to be used or read as "and".*

NOTE: For 2.3 Asthma Remediation, a member eligible for Enhanced HRSN services having an ESMF indicator for "Uncontrolled Asthma" can be referred for services without an additional attestation. For a member indicating asthma-related needs without an ESMF indicator for "Uncontrolled Asthma", an attestation is required to document uncontrolled asthma. Any member receiving a referral for 2.3 Asthma Remediation is automatically eligible to receive referrals for 2.2a Home Remediation Services: Mold and Pest Remediation and 2.2b Home Remediation Services: Ventilation Improving Systems without any further documentation or provider attestation. Services funded under 2.2 Home Remediation Services will be subject to per-member caps.

Where the ESMF supports a "Yes" Social Care Navigators should first rely on ESMF before requesting a supporting attestation.

Category (population or service)	**Description of criterion**	***One of the following methods indicated below can be used to validate a member's eligibility***			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
Enhanced Population Criteria					
Medicaid High Utilizer (adults and children)	See Enhanced Populations for description of Enhanced	Yes	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	Population criterion				
Enrolled in a NYS Health Home (adults and children)	See Enhanced Populations for description of Enhanced Population criterion	Yes	Yes- Can obtain Health Home confirmation of member's enrollment AND clinical criteria directly (verbal, digital, written)	No	No
Individuals with Substance Use Disorder (SUD)	See Enhanced Populations for description of Enhanced Population criterion	Yes, on ESMF as "EPOP_Other"	Yes	No	No
Individuals with Serious Mental Illness (SMI)	See Enhanced Populations for description of Enhanced Population criterion	Yes, on ESMF as "EPOP_Other"	Yes	No	No
Individuals with Intellectual and Developmental Disability	See Enhanced Populations for description of Enhanced Population criterion	Yes	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
(adults and children)					
Pregnant and Postpartum Persons	See Enhanced Populations for description of Enhanced Population criterion	Yes	Yes	Yes	Substitute Member documentation with a verbal member attestation
Post-Release Criminal Justice-Involved Population with chronic conditions, SUD, or chronic Hepatitis-C	Members who are up to 90 days post-release from incarceration	Yes Note: Only some MCOs may be able to populate this field	No	No	Yes[1]
	Members have a chronic condition*, including Substance Use Disorder or hepatitis C. **A full list of Eligible Chronic Conditions can be found here: Health Home Chronic Conditions (ny.gov)*	Yes	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
High-Risk Children under the Age of 18	See Enhanced Populations for description of Enhanced Population criterion	Yes	Yes	No	No
Clinical Criteria:					
1.1 Navigation Services	N/A (All Medicaid members eligible)	*N/A*			
1.2a Enhanced HRSN Care Management – Eligibility Assessment Level 2 Only 1.2b Enhanced HRSN Care Management – Care Management Level 2 Only	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
2.1 Medically necessary Home	Documentation from member's	No	Yes; **Required**	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
Accessibility and Safety Modifications (Ramps, handrails, grab bars etc.)	provider attesting to medical necessity of modification due to physical disability that limits independence				
2.2a Medically necessary Home Remediation Service: mold / pest remediation	Has a health condition or is at-risk for a health condition that is exacerbated by the individual's physical living environment	No	Yes; **Required**	No	No
	Medical necessity of Home Remediation Service	No	Yes; **Required**	No	No
2.2b Medically necessary Home	Previous heat-related illness requiring emergency	Yes; Previous heat-related illness requiring emergency room or urgent care visit, within the last	Yes	Yes; **Required only for "occurred**	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
Remediation Service: Medically necessary air conditioners, heaters, humidifiers, dehumidifier	room or urgent care visit, within the last 12 months that occurred at home	12 months included in ESMF		**at home"** portion of criteria, in addition to either ESMF data OR provider attestation for remainder of criteria	
	Previous cold-related illness requiring emergency room or urgent care visit within last 12 months that occurred at home	Yes; Previous cold-related illness requiring emergency room or urgent care visit, within the last 12 months included in ESMF	Yes	Yes; **Required only for "occurred at home"** portion of criteria, in addition to either ESMF data OR provider attestation for remainder of criteria	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	Chronic condition (such as diabetes, congestive heart failure (CHF), chronic kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS)	Yes	Yes	No	No
	Individuals regularly taking medications or have an otherwise stated	Yes	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	condition that interferes with daily thermoregulation				
2.2c Medically necessary Home Remediation Service: Refrigeration units	Member is a pregnant person/postpartum that requires refrigeration for breast milk	Yes	No	Yes	No
	Prescribed medication requiring refrigeration for the management of a chronic condition	No	Yes; **Required**	No	No
	Enteral or parenteral nutrition	Yes	Yes	No	No
2.3 Asthma Remediation	One or more hospital inpatient stays(s) related to asthma within	Yes	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	the last 12 months				
	Two or more ED visits related to asthma within last 12 months	Yes	Yes	No	No
	Three or more urgent care visits related to asthma within the last 12 months	Yes	Yes	No	No
	Two or more prescribing events for oral steroid use related to an asthma diagnosis within the last 12 months	Yes	Yes	No	No
	Three to eleven prescribing events for rescue inhaler including	Yes	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	albuterol within the last 12 months				
2.4 (Recuperative Care) Medical Respite - Pre and Post Hospitalization	Pre-procedure: Requiring pre-surgical or procedure care as indicated by a medical professional	No	Yes required; if not indicated in the referral package	No	No
	Post-hospitalization: Transitioning from institutions or acute care hospitalization related to a health condition or illness, and Requiring recuperation and care for an illness or injury, and	No	Yes required; if not indicated in the referral package	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	At-risk for incurring other Medicaid State Plan services, such as inpatient hospitalization or emergency department visits				
	Member is homeless or at-risk of homelessness as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	No	Yes; if not indicated in the referral package	Yes – for Category 1: Literally homeless individuals only as defined by HUD	Yes[2]
2.5 Rent / Temporary Housing (Rental Subsidy and	Individuals who have a chronic condition, including	Yes	Yes; **Required for transitioned out of institutional**	No	Yes, written verification (e.g., discharge summary from institutional /

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
Back Rent) for up to 6 months	mental health conditions and physical disability and transitioned out of institutional care/congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals in		**care / congregate settings if written verification is not otherwise provided by the institutional/congregate setting**		congregate settings)

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	the past 90 days				
	Member is homeless or at-risk of homelessness as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	No	Yes	Yes - for Category 1: Literally homeless individuals only as defined by HUD	Yes[3]
	Member is a youth transitioning out of the child welfare system including foster care	No	No	No	Yes[4]; **Required**
2.6 Utility Setup / Assistance	Individuals who have a chronic condition, including mental health conditions	~~*To be determined*~~ Yes; if needed in conjunction with rent	Yes	No	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	and physical disability and transitioned out of institutional care/congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals in the past 90 days				

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	Member is homeless as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	No	Yes	Yes - for Category 1: Literally homeless individuals only as defined by HUD	Yes[5]
	Youth transitioning out of the child welfare system including foster care	No	No	No	Yes[6]; **Required**
2.7 Pre-Tenancy Services	Any Enhanced Population who is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban	*Refer to pathways per each Enhanced Population and homelessness or at-risk of homelessness above (defined in 2.5 Rent or 2.4 Medical Respite)*			

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	/Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).				
2.8 Community Transitional Supports	Any Enhanced Population who is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	*Refer to pathways per each Enhanced Population and homelessness or at-risk of homelessness above (defined in 2.5 Rent or 2.4 Medical Respite)*			

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
2.9 Tenancy Sustaining Services	Any Enhanced Population who is homeless or at-risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	*Refer to pathways per each Enhanced Population and homelessness or at-risk of homelessness above (defined in 2.5 Rent or 2.4 Medical Respite)*			
2.10 Housing Transition and Navigation Services	Any Enhanced Population who is homeless or at-risk of becoming homeless as defined by the U.S.	*Refer to pathways per each Enhanced Population and homelessness or at-risk of homelessness above (defined in 2.5 Rent or 2.4 Medical Respite)*			

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).				
3.1 Nutrition Counseling and Education	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
3.2a Medically Tailored Meals	Any Chronic condition indication listed on the ESMF (per clinical criteria accepted by Health Homes) such as diabetes, congestive heart failure (CHF), chronic	Yes, inclusive of all clinical criteria indicated OR Pregnant and postpartum persons OR Enhanced Population eligibility for: Health Home enrollment on "EPOP_HHENROLLED", SUD or SMI within the "EPOP_Other" field, I/DD within the "EPOP_IDD" field"	Yes. Additionally, can confirm Health Home enrollment directly with Health Home care manager.	Yes, Member verbal attestation can only be utilized if Member is pregnant or post-partum. A verbal confirmation can also	No

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS), OR • Pregnant and postpartum persons OR Enhanced Population eligibility for: Health Home enrollment on "EPOP_HHENROLLED", "EPOP_IDD", SUD or SMI within the			be obtained directly from Health Home if member is enrolled.	

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
	"EPOP_Other" field.				
3.2b Clinically Appropriate Home Delivered Meals	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	Limited to the following Enhanced Populations: • Pregnant and postpartum persons • High-risk children under the age of 18	*Refer to pathways per each Enhanced Population above*			
3.5 Cooking Supplies	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			

Category (population or service)	Description of criterion	*One of the following methods indicated below can be used to validate a member's eligibility*			
		ESMF	**Provider Attestation Form/Email Attestation confirmation or MCO/Health Home verbal or written confirmation**	**Member Attestation**	**Member documentation**
4.1 Transportation related to HRSN service or care management	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			

1. Acceptable forms of member documentation for the Post-Release Criminal Justice-Involved Population criteria "Members who are up to 90 days post-release from incarceration" include one document from the list below:

- Formal release paperwork (e.g., certificate of discharge)
- Email from employee of government agency (e.g., parole, probation officers, case worker, school administrator)

2. Acceptable forms of member documentation for the 2.4 Medical Respite criteria "Member is homeless or at-risk of homelessness as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)" include one document from the list below:

- Written observation by an outreach worker as documented in Social Care Plan via case notes or other type of indicator (i.e., checkbox)
- Written referral by a housing or service provider or shelter
- Written verification (e.g., discharge summary, referral letter) from a hospital or Medical Respite
- A court order resulting from an eviction action notifying the individual or family that they must leave
- For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay
- Certification by the state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute **and** certification of no permanent housing in last 60 days **and** Documentation of special needs or 2 or more barriers

3. Acceptable forms of member documentation for the 2.5 Rent/Temporary Housing criteria "Member is homeless or at-risk of homelessness as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)" include one document from the list below:

- Written observation by an outreach worker as documented in Social Care Plan via case notes or other type of indicator (i.e., checkbox) in lieu of hard documentation uploaded
- Written referral by another housing or service provider
- A court order resulting from an eviction action notifying the individual or family that they must leave
- For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay
- Certification by the state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute **and** certification of no permanent housing in last 60 days **and** Documentation of special needs or 2 or more barriers

4. Acceptable forms of member documentation for the 2.5 Rent/Temporary Housing criteria "Member is a youth transitioning out of the child welfare system including foster care" include one document from the list below:

- Statement from state or county agency verifying member is involved in Child Welfare is in or was in their custody
- Statement from agency responsible for member's placement verifying they are or were in the custody of the State
- Copy of court documents/order verifying the member is in or was in the custody of the state or county
- Copy of Foster Care Transition plan

5. Acceptable forms of member documentation for the 2.6 Utility Setup/Assistance criteria "Member is homeless or at-risk of homelessness as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)" include one document from the list below:

- Written observation by the outreach worker
- Written referral by another housing or service provider
- A court order resulting from an eviction action notifying the individual or family that they must leave
- For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay
- Certification by the state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute **and** certification of no permanent housing in last 60 days **and** Documentation of special needs or 2 or more barriers

6. Acceptable forms of member documentation for the 2.6 Utility Setup/Assistance criteria "Youth transitioning out of the child welfare system including foster care" include one document from the list below:

- Statement from state or county agency verifying member is involved in Child Welfare is in or was in their custody
- Statement from agency responsible for member's placement verifying they are or were in the custody of the State
- Copy of court documents/order verifying the member is in or was in the custody of the state or county
- Copy of Foster Care Transition plan

vi. Geographic location of service delivery

In some cases, delivery of Enhanced HRSN Services will be limited to a member's primary address. The table below includes details on locations to which services may be delivered.

Table 5-17: Service delivery locations for HRSN Enhanced Services

Services that are delivered to home	Services delivered to members 18+	Services delivered to children (<18)
Home Modification services	Services must be delivered to primary address	Services may be delivered to an alternative address
All other services	Services may be delivered to an alternative address	Services may be delivered to an alternative address

vii. Covered Enhanced HRSN Services

Additional details regarding the Enhanced HRSN services covered are described below. For each Covered HRSN Service area (e.g., Care Management, Housing, Nutrition, and Transportation Services) details below include:

- Description of service
- Eligibility and service details table
  - Eligibility requirements
  - Service limitations and restrictions
  - Allowable provider
- Workflow, if applicable

Table 5-18: Enhanced HRSN services included in the SCN program

HRSN Category	Enhanced HRSN Service
Care Management	1.1 Navigation Services (Eligibility Assessment and Navigation)
	1.2 Enhanced HRSN Care Management (1.2a Eligibility Assessment and 1.2b Enhanced HRSN Care Management – Care Management for the Enhanced Population)
Housing	2.1 Home Accessibility and Safety Modifications
	2.2 Home Remediation Service
	2.3 Asthma Remediation
	2.4 Recuperative Care (Medical Respite)
	2.5 Rent / Temporary Housing (Rental Subsidy and Back Rent)
	2.6 Utility Setup / Assistance
	2.7 Pre-Tenancy Services

	2.8 Community Transitional Supports (CTS)
	2.9 Tenancy Sustaining Services
	2.10 Housing Transition and Navigation Services
Nutrition	3.1 Nutrition Counseling and Education
	3.2a Medically Tailored Meals, and 3.2b Clinically Appropriate Home Delivered Meals
	3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions
	3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)
	3.5 Cooking Supplies
Transportation	4.1 Transportation Services

1. Care Management

Care Management involves Eligibility Assessment, planning, education, outreach, facilitation, member and non-member facing care coordination efforts, and advocacy for options and services to meet an individual's HRSNs through communication and connection to available resources to promote member safety, quality of care, and cost-effective outcomes. Social Care Navigators will work with members to connect them to the appropriate services to address their HRSNs that align with the members' preferences, limitations, disabilities, etc. Social Care Navigators can perform Care Management for the Enhanced Population.

Care Management for either Navigation services or Enhanced HRSN Services will begin immediately by the Social Care Navigator for any Medicaid member that has an unmet HRSN based on responses to the questions in the AHC HRSN Screening Tool and has a completed Eligibility Assessment

1.1 Navigation Services (Eligibility Assessment and Navigation)

Navigation Services (Eligibility Assessment and Navigation) is only available for Medicaid FFS members and non-eligible Medicaid Managed Care members who were screened, have an identified unmet HRSN and subsequently receive an Eligibility Assessment under this service. These members may be navigated to existing federal, state, and local benefits and programs. Medicaid FFS members and non-eligible Medicaid Managed Care members will not receive access to Enhanced HRSN Services funded under the 1115 Waiver. Social Care Navigators may bill for member and non-member facing time spent on the Eligibility Assessment and Navigation.

During the Eligibility Assessment and when navigating to existing services, Social Care Navigators will be required to select granular ICD-10 and SNOMED-CT descriptions of a member's unmet need within the SCN IT Platform per the Social Care Coding document. After a member agrees to navigation, Social Care Navigators must change the status to "Completed".

Table 5-19: Navigation: Eligibility and service details

Navigation: Eligibility and service details	
Eligibility	1. Medicaid FFS members who have an identified unmet HRSN; or

	2. Medicaid Managed Care members who have an identified unmet HRSN but do not meet the criteria for populations eligible for Enhanced HRSN Services 3. This is not used for the Enhanced Population
Service Limitations and Restrictions	1. Medicaid members may access Navigation upon one annual Screening (or Re-Screening due to a major life event) for support with accessing federal, state, or local services during the demonstration period
Allowable Providers	1. Social Care Navigators may include employees of the SCN Lead Entity or networked HRSN service providers 2. Social Care Navigators providing Navigation Services should have experience assisting underserved populations with connection to services 3. Social Care Navigators providing Navigation Services must participate in trainings to ensure that services meet expectations (as defined in d. Training expectations) including cultural and linguistic training

1.2 Enhanced HRSN Services Care Management (Eligibility Assessment and Enhanced Care Management for the Enhanced Population)

Enhanced HRSN Services Care Management (Eligibility Assessment and Enhanced Care Management) is only available for eligible Medicaid Managed Care members that are part of the Enhanced Population eligible for Enhanced HRSN Services.

1.2a Eligibility Assessment: Social Care Navigators may bill for member and non-member facing time spent on the Eligibility Assessment for the Enhanced Population per the HRSN Fee Schedule, "Enhanced HRSN Care Management – Eligibility Assessment Level 2 Only". During the Eligibility Assessment and when making referrals, Social Care Navigators will be required to select granular ICD-10 and SNOMED-CT description of a member's unmet need. Following the Eligibility Assessment, Social Care Navigators will also be required to select granular ICD-10 and SNOMED-CT to capture the specific nature of Navigation support provided and specific Enhanced HRSN services to which members are referred.

1.2b Enhanced Care Management: For the NYHER population eligible for Enhanced HRSN Services, the Social Care Navigator has the responsibility of providing Enhanced Care Management which includes: referral management, member facing and non-member facing care coordination (including connection to clinical care management), education and confirming with the member whether the referral was accessed and whether their needs were met. Social Care Navigators will coordinate, if applicable, the application process and application fees to assist members in securing essential services such as housing, transportation, employment, etc. Examples of covered costs include costs associated with obtaining copies of vital records (i.e. birth certificate), obtaining non-driver identification, driver's license application fees at the DMV, background check fees, and housing application fees.

Social Care Navigators may bill for member and non-member facing time spent on Enhanced Care Management per the HRSN Fee Schedule under procedure codes for Enhanced HRSN Care Management – Care Management Level 2 Only and Enhanced Care Management – Follow Up Level 2 Only.

The Social Care Navigator may use Enhanced Care Management codes to bill for member and non-member facing time spent making and managing member referrals and conducting follow-ups before and after service delivery (per Table 5-9) for all Enhanced HRSN Services. Social Care Navigators may also use Enhanced Care

Management codes to bill for navigating members transitioning from Enhanced HRSN Services to existing federal, state, and local resources.

The Social Care Navigator may also use Enhanced Care Management procedure codes to bill for member and non-member facing time spent on coordination activities related to select Enhanced HRSN services (outlined below) for the member if the contracted HRSN service provider is not performing coordination for the services. If the HRSN service provider does conduct the coordination, they should bill according to guidance for each service (*see individual services in Covered HRSN Services).*

- Transportation (e.g., arrange private transportation, coordinate public transportation vouchers)
- Cooking Supplies (e.g., discuss cooking supplies needs with member, order cooking supplies)
- Home Accessibility and Safety Modifications (e.g., submit SOW for Technical Review, review SOW and select services, get member approval for services)
- Home Remediation Service (e.g., submit SOW for Technical Review, review SOW and select services, get member approval for services)
- Asthma Remediation (e.g., call member to determine timing for ASME visit, review findings from ASME visit, submit SOW for Technical Review, review SOW and select services)
- Community Transitional Supports (CTS) (e.g., discuss furnishing needs, collecting bills or receipts)
- Utility Setup / Assistance (e.g., collect utility bills from member, coordinate utility bill payments)
- Rent / Temporary Housing (Rental Subsidy and Back Rent) (e.g., submit rental payments directly to landlord)
- Recuperative Care (Medical Respite) (e.g., coordinate transitional services with MRP prior to member discharge)

The Social Care Navigator will further create Social Care Plans with the member to determine ongoing needed services including Enhanced HRSN Services, refer, track, and follow-up with services the member is eligible for and opts into.

SCN LEs must establish a workflow to ensure members are connected via a warm hand-off to clinical care management providers when members are interested and potentially eligible for services; connection to clinical care management is billable under Enhanced Care Management.

Table 5-20: Enhanced HRSN Services Care Management (Enhanced Services Population): Eligibility and service details

Enhanced HRSN Services Care Management (Enhanced Services Population): Eligibility and service details	
Eligibility	1. Must be an enrolled Medicaid Managed Care member; 2. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-12
Service Limitations and Restrictions	1. Enhanced Care Management may be a standalone service, without a member receiving services in any other Enhanced HRSN Services domain 2. Enhanced Care Management may be re-authorized up to the duration of the Waiver. Member must continue to have an unmet need and remain eligible to receive this service.

Enhanced HRSN Services Care Management (Enhanced Services Population): Eligibility and service details	
	3. Members may be engaged in multiple services under Enhanced Care Management as long as the total monthly units are at or below the aggregate service cap as outlined in the HRSN Fee Schedule 4. Social Care Navigators will provide Enhanced Care Management related to HRSNs only and will not provide any clinical Care Management 5. Enhanced Care Management is the equivalent of Navigation under the non-Enhanced Population 6. Social Care Navigator may bill for units of Enhanced Care Management that are delivered over multiple days (e.g., if Eligibility Assessment requires multiple interactions with a member). Social Care Navigators may create a single invoice for interactions spanning up to 5 days.
Allowable Providers	1. Social Care Navigators may include employees of the SCN Lead Entity or of organizations that are contracted as part of the Network 2. Social Care Navigators should have experience connecting underserved populations to services 3. Social Care Navigators **must participate in trainings to ensure that services meet expectations** (as defined in d. Training expectations)

2. Housing

The New York's 1115 Waiver makes available several Housing support services to meet enrolled Medicaid Managed Care member's needs. These Housing supports are intended to create housing equity, accessibility, safety, and sustainability to help prevent adverse health and social impacts.

When HRSNs are not directly addressed by the below Housing / Utility services (e.g., fire alarms, lead paint exposure programs, etc.), the Social Care Navigator may refer members to existing federal, state, and local services. SCNs can accept a member's verbal attestation of services received to-date from their MLTCP/MAP plan pertaining to the below services:

- 2.1 Home Accessibility and Safety Modifications
- 2.2 Home Remediation
- 2.3 Asthma Remediation
- 2.8 CTS
- 2.10 Housing Transition and Navigation Services

Social Care Navigators may refer MLTCP and MAP members to other housing services without coordinating with a member's MCO case manager but are encouraged to do so to support member experience and coordination.

i. Non-Invasive Measures and Asthma Trigger Remediation Services/Asthma Supportive Products

Under services 2.1 Home Modification, 2.2 Home Remediation, and 2.3 Asthma Remediation, specific services that are not considered an invasive measure do not need SOW TA approval. An Invasive Measure is defined as any residential modification or remediation that may have a detrimental health, safety, or building impact on the member(s) or household if not properly installed and inspected. Such invasive measures require landlord approval.

For dwellings requiring deep cleaning prior to proceeding with the provision of home modifications, mold remediation and/or Integrated Pest Management (IPM), cleaning services can be billed towards the member's overall cap within 2.1 Home Accessibility and Safety Modifications, 2.2a Mold and Pest Remediation, 2.2b Ventilation Improving Systems or 2.3 Asthma Remediation and provided prior to SOW development or SOW technical review if needed.

If the member or landlord does not consent to invasive measures within the SOW, the Social Care Navigator can ~~following items are considered non-invasive and do NOT~~ still offer the member the below non-invasive measures without ~~need~~ a SOW ~~technical review~~. The Social Care Navigator must track the costs of these non-invasive measures towards the member's overall cap in addition to any subsequent costs defined in the SOW.

2.1 Home Accessibility and Safety Modifications:

2.1a Non-skid surfaces

2.2 Home Remediation Service:

2.2a Mold and Pest Remediation: non-invasive measures only

2.2b Ventilation Improving Systems: Medically necessary improvement of ventilation systems, which include provisions of devices and appliances that are eligible by clinical criteria:

- Air conditioners;
- Heaters (i.e., electric space heaters with automatic shut-off safety feature)
- Humidifiers;
- Dehumidifiers;
- Air filtration devices (which may be limited to mechanical only)

2.2c Equipment Provision: Provision of medically necessary mini refrigeration units as needed for medical treatment and prevention (e.g., insulin)

2.3 Asthma Remediation: Trigger Remediation Services and Asthma Supportive Products

The following asthma trigger remediation services and asthma supportive products are considered non-invasive and may be provided by the ASME provider AND given to the member prior to SOW development if needed.

If the member declines proceeding with 2.3b (the dwelling assessment and SOW development) or if the landlord does not consent to a SOW including invasive measures, the Social Care Navigator should proceed with the full scope of 2.3a (ASME) which includes initial ASME visit, final ASME visit, and provision of non-invasive supportive products if necessary under 2.2a Mold and Pest Remediation, 2.2b Ventilation Improving Systems and 2.3 Asthma Remediation, and Enhanced Care Management. The Social Care Navigator must track the costs of non-invasive measures towards the member's overall cap within 2.2a Mold and Pest Remediation, 2.2b Ventilation Improving Systems and 2.3 Asthma Remediation, in addition to any subsequent costs defined in the SOW.

Table 5-21: Asthma Remediation

Asthma Trigger Remediation Services	Asthma Supportive Products
Indoor Air Quality	**Asthma Friendly Cleaning Supplies**
Provision of: • Installation of air conditioner • Carpet steam cleaning • Replacement of air filters in HVAC system	Provision of: • Hygrometer (Humidity gauge) • Microfiber cleaning cloths • Green scrubbers • Cleaning buckets and spray bottle • Microfiber mop • Castile soap • Cleaning vinegar (with recipe for mixing)
Integrated Pest Management (IPM) (non-invasive only)	Indoor Allergen Reduction
Provision of: • Airtight food storage containers	Provision of: • Vacuum with HEPA filter and filter replacements • Allergen impermeable pillow and mattress encasement

Table 5-22: Housing / Utilities Screening questions

Housing / Utilities Screening questions	
1. What is your living situation today?	• I have a steady place to live • I have a place to live today, but I am worried about losing it in the future • I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	• Pests such as bugs, ants, or mice • Mold • Lead paint or pipes • Lack of heat • Oven or stove not working • Smoke detectors missing or not working • Water leaks • None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	• Yes • No • Already shut off

2.1 Home Accessibility and Safety Modifications

These services are available for a home that is owned, rented, leased, or occupied by the Medicaid member or their caregiver. Home Accessibility and Safety Modifications consist of the following elements:

- ***Dwelling Assessment & SOW Development****:* A comprehensive dwelling assessment of the primary residence to identify Home Accessibility and Safety Modifications needed. Assessment should be conducted by a qualified home improvement contractor with industry-standard credentials in building science. The SOW should outline recommended Home Modifications based on the assessment. Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project

- ***SOW Technical Review****:* Each SOW should be reviewed by a qualified reviewer with industry-standard credentials in building science, working independently of the HRSN service provider that performs the Home Accessibility and Safety Modifications installation. The SOW Technical Review should indicate which services in the SOW are invasive. If the SOW includes invasive measures, written approval from the property owner (landlord in case of a rental) is required before beginning work (approval must be obtained by either the Social Care Navigator or service provider)

- ***Home Accessibility and Safety Modifications****:* Limited internal or external physical adaptations made to eligible member's home or community dwelling when necessary to ensure maximum health, welfare, and safety, or to allow the member to live independently in a community-based setting. All installation services include general education on how to use and properly care for equipment during installation.

  Medically necessary Home Accessibility and Safety Modifications that are eligible by clinical criteria:
  - Accessibility ramps
  - Handrails; Grab bars
  - Electric door openers,
  - Widening of doorways; Pathways
  - Door and cabinet handles
  - Bathroom facilities; Kitchen cabinet or sinks; Non-skid surfaces
  - Home Modifications will be limited to those listed above and which are recommended in the SOW and approved by the Social Care Navigator after the SOW Technical Review.

  Member written approval is required to begin installation of approved SOW services. Services involving invasive measures require written approval from the property owner (landlord, if the residence is rented). HRSN service providers must provide proof of credentials/licensure/industry-accepted certifications and training (including advanced requirements for specialized services such as HVAC, IPM, etc.). Total costs of services for Home Accessibility and Safety Modifications and Home Remediation may not exceed per member cap listed in the HRSN Fee Schedule for duration of Waiver period

- ***Quality Assurance (QA) Inspection****:* Within 90 days of service completion, a QA Inspection should be conducted in alignment with Building Performance Institute (BPI) and other industry technical standards for QA for a minimum of 10 percent of households where Home Accessibility and Safety Modification services are provided by the SCN. QA provider should be independent of provider of Home Accessibility

and Safety Modifications. If a QA Inspection identifies any issues with the work completed, the Social Care Navigator should work with the HRSN service provider to ensure work passes the QA Inspection.

Table 5-23: Home Accessibility and Safety Modifications: Eligibility and service details

Home Accessibility and Safety Modifications: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14; 2. Meets the clinical criteria in Table 5-15; and 3. Is determined to be clinically necessary by the member's provider; and 4. Is determined to have a need for modification and remediation services to increase and/or improve home accessibility and safety by a Social Care Navigator. 5. Eligible Medicaid Managed Care member must be a resident of a single-family or multi-unit primary residence owned or rented by the member or a primary caregiver
Service Limitations and Restrictions	1. If applicable, Social Care Navigators must document the qualifying clinical criteria for home and safety modifications in the member's Social Care Plan 2. Modification services are limited to those that are of direct medical or remedial benefit to the Medicaid Managed Care member 3. Home Accessibility and Safety Modifications must be conducted in accordance with applicable state and local building codes 4. Prior to service delivery, the Social Care Navigator should collect documentation which verifies the member's address • Members who own their home are required to submit the following: o Proof that homeowner owns the home: deed of home, property tax statement, OR mortgage documentation including homeowner's name and address • If the member does not own their home, the member will be required to submit: o Proof that member resides in the home: lease or rent-owed form or utility bill from the past 90 days OR o Any of the documentation under homelessness criteria that includes member address, as listed in Table 5-16 5. Services involving invasive measures will require written approval from property owner (landlord, if the residence is rented) • Property owner will also need to provide proof of homeownership through one of the following: deed of home, property tax statement, OR mortgage documentation including homeowner's name and address 6. Eligible Medicaid Managed Care member must be a resident of a single-family or multi-unit primary residence owned or rented by the member or a primary caregiver 7. Total combined costs of services for Home Accessibility and Safety Modifications and Home Remediation Service, including Dwelling Assessment & SOW Development, SOW Technical Review, Home Modifications, and QA Inspection, as needed, may not exceed per member cap listed in HRSN Fee Schedule for duration of Waiver period

Home Accessibility and Safety Modifications: Eligibility and service details	
	8. HRSN service providers must consult with the member's locality for any required permits prior to beginning invasive measures listed within the SOW
Allowable Providers	1. Contracted Home Modification HRSN service providers that are designated as a non-profit community-based organization 501 (c)(3) or 501(c)(4) 2. Contracted Home Modification services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501 (c)(3) or 501(c)(4) community based organization. (*For additional details, see HRSN Network Capacity and Access*) 3. Service providers should have knowledge and experience with providing related Home Accessibility and Safety Modifications. Service providers must have proof of credentials/ licensure and/or industry-accepted certifications and training specific to the services being proposed. Physical adaptations to a residence must be performed by an individual holding a New York State Contractor's License 4. Either the SCN or a contracted organization that is part of the Network can contract with the modification / remediation / ventilation company 5. Modifications must be conducted in accordance with applicable state and local building codes 6. Dwelling Assessment and SOW Development must be conducted by a qualified home improvement contractor with proof of industry-standard credentials in building science 7. SOW Technical Review and QA Inspection must be conducted by a qualified reviewer/inspector holding industry-standard credentials in building science and working independently of the HRSN service provider for Home Accessibility and Safety Modifications 8. HRSN service providers completing Home Accessibility and Safety Modifications must have proof of credentials/licensure/industry-accepted certifications and trainings AND demonstrated experience providing Home Modifications

Workflow for Home Accessibility / Safety Modification Service: The SCN Lead Entity will need to create a unique workflow for Home Accessibility / Safety Modification services based on the Dwelling Assessment, SOW Development, Home Modifications, and QA Inspection. In general, the workflow should follow the below steps (*see Figure 5-7 for a visual process flow*):

1. The Social Care Navigator will refer the member to an HRSN service provider to complete a Dwelling Assessment and develop an SOW.
2. The HRSN service provider will conduct the Dwelling Assessment and SOW Development and provide the SOW to the Social Care Navigator via the IT Platform. The SOW will include the physical adaptations and modifications necessary to ensure maximum health, welfare, and safety, or to allow the member to function independently in their home. Only one Dwelling Assessment and SOW is required. The provider that conducts the Dwelling Assessment and develops the SOW can be reimbursed for admin time, including travel.

3. The Social Care Navigator will submit the SOW for Technical Review to a qualified reviewer holding industry-standard credentials in building science working independently of the HRSN service provider for the Home Accessibility and Safety Modifications.
4. The provider conducts the SOW Technical Review, indicates within the SOW which services involve invasive measures, and returns the SOW to the Social Care Navigator.
5. The Social Care Navigator will review the SOW and select the appropriate services to authorize for the member to receive (Note: HRSN service provider may recommend services that are not covered under the NYHER Enhanced HRSN Services. In those instances, the Social Care Navigator may connect member to applicable federal, state, local programs). The total cost for Home Accessibility and Safety Modification services must be at or below the allowable cap amount in the HRSN Fee Schedule. If recommended services are above the allowable cap, the Social Care Navigator, in consultation with the Technical Reviewer, must prioritize appropriate services to authorize for the member to remain under the cap. The Social Care Navigator must enter and create unique referrals for each service included in the approved SOW and document authorized services within the Social Care Plan.
6. The Social Care Navigator must ensure member written approval of approved SOW services to begin modification services. Any SOW involving invasive measures, as confirmed by the SOW Technical Review, also requires written approval from the property owner (landlord, if the residence is rented).
7. The Social Care Navigator makes a referral to HRSN service provider for Home Accessibility and Safety Modifications. Service providers for Home Accessibility and Safety Modifications and/or their subcontractors must provide proof of credentials/licensure/industry-accepted certifications and training. The HRSN service provider or subcontractor proceeds with completing Home Accessibility and Safety Modifications as approved in the SOW. The HRSN service provider for Home Accessibility and Safety Modifications may be the same or different entity for the Dwelling Assessment and SOW Development.
8. Provider completes Home Accessibility and Safety Modification services.
9. For a minimum of 10 percent of households where Home Accessibility and Safety Modifications services are provided (as determined at the discretion of the SCN Lead Entity), QA Inspection should be conducted by a qualified inspector holding industry-standard credentials in building science, within 90 days of completion of Home Accessibility and Safety Modifications. Provider of QA Inspection must be independent of the HRSN service provider for Home Accessibility and Safety Modifications. If a QA Inspection identifies any issues with the work completed, the Social Care Navigator should work with the HRSN service provider to ensure work passes the QA Inspection
10. The HRSN service provider for Home Accessibility and Safety Modifications updates the SCN IT Platform to demonstrate the services within the SOW have been completed.
11. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the member within 5 business days to document their satisfaction.

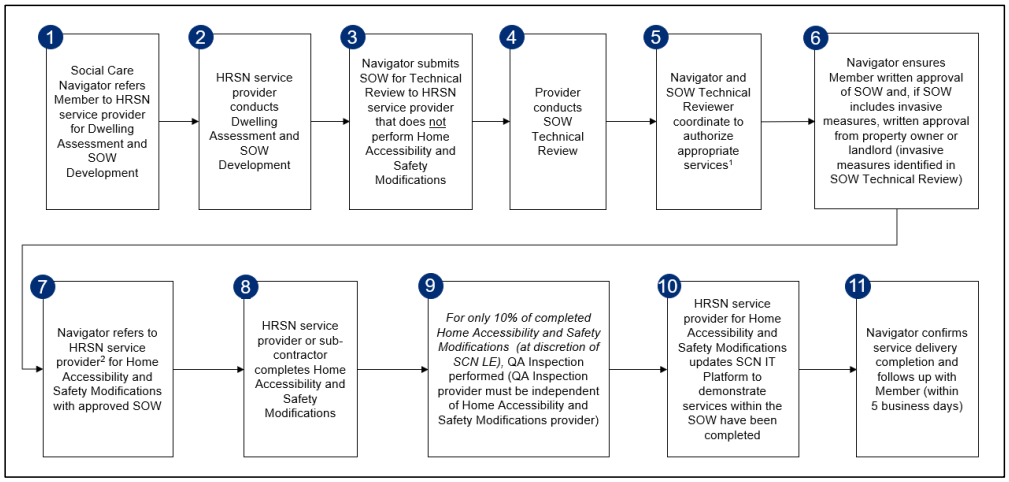
Note: If the cost of services is $2,000 or more, the HRSN service provider must either:

a. Obtain at least three bids for any total work of $2,000 or more and select the lowest price and best value or substantially equivalent bid, if applicable. ~~Bid solicitation for a specific SOW occurs *after* the SOW is approved (during step 7 in the outlined workflow). (~~As a last resort, the SCN Lead Entity may move forward with only two bids if there is limited capacity within SCN region.

b. If preferred, the SCN Lead Entity can establish a list of preferred contractors through a competitive bidding process to be updated annually, and the HRSN service provider can select a contractor for recommended modifications from this list without soliciting at least 3 bids for each service.

Across both options, bid development (e.g., time spent traveling to the site, writing up the bid) will not be reimbursed.

Figure 5-7: Process flow for Home Accessibility and Safety Modification services



[1]Contracted Network organization may suggest services that are not covered under the SCN Lead Entity Enhanced HRSN Services. SCN Lead Entity may authorize ONLY the approved Enhanced HRSN Services
[2]Refer to bidding process in workflow above

2.2 Home Remediation Services

These services are available for a home that is owned, rented, leased, or occupied by the Medicaid member or their caregiver. Home Remediation Service will consist of the following elements:

- *Dwelling Assessment & SOW Development:* A comprehensive dwelling assessment of the primary residence to identify Home Remediation Service needed. Assessment should be conducted by a qualified home improvement contractor with industry-standard credentials in building science. The SOW should outline recommended Home Modifications based on the assessment. Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project
- *SOW Technical Review:* Each SOW should be reviewed by a qualified reviewer with industry-standard credentials in building science, working independently of the HRSN service provider that performs the Home Remediation Service. The SOW Technical Review should indicate which services in the SOW are invasive. If the SOW includes invasive measures, written approval from the property owner (landlord in

case of a rental) is required before beginning work (approval must be obtained by either the Social Care Navigator or service provider)

- *Home Remediation Services:* Home Remediation Services *are* limited to repairs or remediations to an eligible member's home or community dwelling. They are a cost-effective method for addressing the occupant's health condition and must be recommended by a health care professional or indicated on the MCO's Enhanced Services Member File. Total combined costs of services for Home Accessibility and Safety Modifications and Home Remediations may not exceed per member cap listed in HRSN Fee Schedule for duration of Waiver period

  These services and provisions in 2.2a, 2.2b and 2.2c are available in a home that is owned, rented, leased, or occupied by the eligible Medicaid member or their caregiver. Member written approval is required to begin installation of approved SOW services. Services involving invasive measures require written approval from the property owner (landlord, if the residence is rented). HRSN service providers must provide proof of credentials/licensure/industry-accepted certifications and training (including advanced requirements for specialized services such as HVAC, IPM, etc.)

- *QA Inspection:* Within 90 days of service completion, a QA Inspection should be conducted in alignment with Building Performance Institute (BPI) and other industry technical standards for QA for a minimum of 10 percent of households where Home Remediation Services is provided by the SCN. QA provider should be independent of provider of Home Remediation Services. If a QA Inspection identifies any issues with the work completed, the Social Care Navigator should work with the HRSN service provider to ensure work passes the QA Inspection

2.2a Mold and Pest Remediation: Home Remediation Services to promote member's health and wellbeing may include:

- Mold remediation (including fixing water leaks and removing damp or wet items to prevent mold growth).
- Pest remediation (including sealing / patching holes and cracks through which pests can enter the home).

2.2b Ventilation Improving Systems: Medically necessary improvement of ventilation systems, which include provisions of devices and appliances that are eligible by clinical criteria:

- Air conditioners;
- Humidifiers;
- Dehumidifiers;
- Heaters (i.e., electric space heaters with automatic shut-off safety feature);
- Air filtration devices (which may be limited to mechanical only).

2.2c Equipment Provision: Provision of medically necessary mini refrigeration units as needed for medical treatment and prevention (e.g., insulin)

Table 5-24: Home Remediation Services: Eligibility and service details

Home Remediation: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14; 2. Meets the clinical criteria in Table 5-15; and 3. For 2.2a, has required provider attestation 4. Is determined to have a need for Home Remediation to reduce / eliminate environmental triggers for acute respiratory episodes and improved home accessibility and safety by a Social Care Navigator 5. Eligible Medicaid Managed Care member must be a resident of a single-family or multi-unit primary residence owned or rented by the member or a primary caregiver
Service Limitations and Restrictions	1. Social Care Navigator must document the qualifying clinical criteria (Table 5-15) for Home Remediation Service in the member's Social Care Plan 2. Remediation services are limited to those that are of direct medical or remedial benefit to the Medicaid Managed Care member and are not to be used for general utility 3. Remediations must be conducted in accordance with applicable state and local building codes 4. Prior to service delivery, the Social Care Navigator should collect documentation which verifies the member's address. • Members who own their home are required to submit the following: o Proof that homeowner owns the home: deed of home, property tax statement, OR mortgage documentation including homeowner's name and address • If the member does not own their home, the member will be required to submit: o Proof that member resides in the home: lease or rent-owed form or utility bill from the past 90 days OR Any of the documentation under homelessness criteria that includes member address, as listed in Table 5-16. Services involving invasive measures will require written approval from property owner (landlord, if the residence is rented). • Property owner will also need to provide proof of homeownership through one of the following: deed of home, property tax statement, OR mortgage documentation including homeowner's name and address 5. Eligible Medicaid Managed Care member must be a resident of a single-family or multi-unit primary residence owned or rented by the member or a primary caregiver 6. Total combined costs of services for Home Accessibility and Safety Modifications and Home Remediation Service, including Dwelling Assessment & SOW Development, SOW Technical Review, remediation services, and QA Inspection may not exceed per member cap listed in HRSN Fee Schedule for duration of Waiver period.

Home Remediation: Eligibility and service details	
	7. HRSN service providers must consult with the member's locality for any required permits prior to beginning invasive measures listed within the SOW
Allowable Providers	1. Contracted Home Remediation Service providers that are designated as a non-profit community-based organization 501(c)(3) or 501 (c)(4) 2. Either the SCN Lead Entity or a contracted Network organization can contract with the remediation / ventilation company 3. Contracted Home Remediation Service may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501 (c)(4) community-based organization. See HRSN Network Capacity and Access section for details 4. Service providers should have knowledge and experience with providing related Home Remediation Service. Service providers must have proof of credentials/ licensure and/or industry-accepted certifications and training specific to the services being proposed. Physical adaptations to a residence must be performed by an individual holding a New York State Contractor's License. 5. Dwelling Assessment and SOW Development must be conducted by a qualified home improvement contractor with proof of industry-standard credentials in building science. 6. SOW Technical Review and QA Inspection must be conducted by a qualified reviewer/inspector holding industry-standard credentials in building science and working independently of the HRSN service provider for Home Remediation Service 7. HRSN service providers completing Home Remediation Service must have proof of credentials/licensure/industry-accepted certifications and trainings (including advanced requirements for specialized services such as HVAC, IPA, mold remediation, etc.) AND demonstrated experience providing Home Modifications

Workflow for Home Remediation Service: The SCN Lead Entity will need to create a unique workflow for the Home Remediation Service based on HRSN service provider's Dwelling assessment, SOW development, Home Remediation Service, and QA Inspection. In general, the workflow should follow the below steps:

1. If the member is eligible for Home Remediation Service, the Social Care Navigator will refer to an Enhanced HRSN service provider to complete the Dwelling Assessment and SOW Development.
2. The HRSN service provider will conduct the Dwelling Assessment and SOW Development and provide the SOW to the Social Care Navigator via the IT Platform. The SOW will determine the physical adaptations and modifications necessary to ensure maximum health, welfare, and safety, or to allow the member to function independently in their home. Only one Dwelling Assessment and SOW is required. The provider that conducts the Dwelling Assessment and develops the SOW can be reimbursed for admin time, including travel.
3. The Social Care Navigator will submit the SOW for Technical Review to a qualified reviewer holding industry-standard credentials in building science working independently of the HRSN service provider for Home Remediation Service.

4. The provider conducts the SOW Technical Review and indicates within the SOW which services involve invasive measures and returns the SOW to the Social Care Navigator.
5. The Social Care Navigator will review the SOW and select the appropriate services to authorize for the member to receive. (Note: HRSN service provider may recommend services that are not covered under the NYHER Enhanced HRSN Services. In those instances, the Social Care Navigator may connect member to applicable federal, state, local programs). The total cost for Home Remediation Service must be at or below the allowable cap amount in the HRSN Fee Schedule. If recommended services are above the allowable cap, the Social Care Navigator, in consultation with the Technical Reviewer, must prioritize appropriate services to authorize for the member to remain under the cap. The Social Care Navigator must enter and create unique referrals for each service included in the approved SOW and document authorized services within the Social Care Plan.
6. The Social Care Navigator must ensure member written approval of approved SOW services to begin remediation services. Any SOW involving invasive measures, as confirmed by the SOW Technical review, also requires written approval from the property owner (landlord if the residence is rented).
7. The Social Care Navigator makes referral to HRSN service provider for Home Remediation Service. Service providers and/or their subcontractors must provide proof of credentials/licensure/industry-accepted certifications and training. The HRSN service provider or subcontractor proceeds with completing Home Remediation Service as approved in the SOW. The HRSN service provider for Home Remediation Service may be the same or different entity that completes the Dwelling Assessment and SOW Development.
8. HRSN service provider completes Home Remediation Service.
9. For a minimum of 10 percent of households where Home Remediation Service is provided (as determined at the discretion of the SCN Lead Entity), QA Inspection should be conducted by a qualified inspector holding industry-standard credentials in building science, within 90 days of completion of Home Remediation Service. Provider of QA Inspection must be independent of the HRSN service provider for Home Remediation Service. If a QA Inspection identifies any issues with the work completed, the Social Care Navigator should work with the HRSN service provider to ensure work passes the QA Inspection.
10. The HRSN service provider for Home Remediation Service updates the SCN IT Platform to demonstrate the services have been completed.
11. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the member within 5 business days to document their satisfaction.

Note: If the cost of services is $2,000 or more, the HRSN service provider must either:

- **a.** Obtain at least three bids for any total work of $2,000 or more and select the lowest price and best value or substantially equivalent bid, if applicable. ~~Bid solicitation for a specific SOW occurs after the SOW is approved (during step 7 in the outlined workflow).~~ As a last resort the SCN Lead Entity may move forward with only two bids if there is limited capacity within SCN region.
- **b.** If preferred, the SCN Lead Entity can establish a list of preferred contractors through a competitive bidding process to be updated annually, and the HRSN service provider can select a contractor for recommended modifications from this list without soliciting at least 3 bids for each service.

Across both options, bid development (e.g., time spent traveling to the site, writing up the bid) will not be reimbursed.

2.3 Asthma Remediation

Remediation services will be available to Enhanced Population members who have a diagnosis of asthma and meet the clinical criteria in Table 5-15. SCN LEs are encouraged to coordinate with their SCN IT Platform vendor to obtain an aggregate ESMF file across MCOs. The aggregate ESMF list can then be filtered by the indicator for Uncontrolled Asthma and shared with contracted partners for targeted outreach attempts.

These services are available for a home that is owned, rented, leased, or occupied by the Medicaid member or their caregiver. Asthma Remediation services entail the provision of remedial services to remove indoor environmental allergens and the provision of supportive products to eliminate or reduce asthma triggers in the member's home. Remediation services will be tailored to the individual needs of the member and the primary residence (owner-occupied or rental dwelling) of the member. Services should address multiple triggers to improve the residence and member's capacity for asthma self-management. Asthma Remediation services will include the following components:

2.3a Asthma Self-Management Education (ASME): Health education tailored to the needs of the member and family/caregivers to expand asthma knowledge, such as early warning signs and management of worsening symptoms, asthma control and medication adherence, and identification and reduction of asthma triggers. ASME should be conducted in alignment with NIH national asthma guidelines and support education for a partnership in asthma care. ASME must be provided by a qualified nonphysician health care professional, such as a certified asthma educator specialist (AE-C), respiratory therapist (RT), or specially trained lay health worker (e.g., health educator, community health worker (CHW), etc.), with documented training and demonstrated competency in delivering guidelines-based Asthma Self-Management Education and comprehensive home environmental assessments to identify and provide education on reducing asthma triggers. ASME must include an asthma and environmental assessment performed in two separate visits. The ASME provider must notify the Social Care Navigator if the member has additional care coordination needs outside of the ASME service (e.g., clinical follow-up) unless the ASME provider is also contracted as a Social Care Navigator. The ASME provider can supply asthma supportive products and indoor allergen reduction products and bill them towards the member's cap.

> NOTE: If the member declines proceeding with 2.3b (the dwelling assessment and SOW development) or if the landlord does not consent to a SOW including invasive measures, the Social Care Navigator should proceed with the full scope of 2.3a (ASME) which includes initial ASME visit, final ASME visit, Enhanced Care Management, provision of non-invasive products and services per Section 2.i Non-Invasive Measures and Asthma Trigger Remediation Services/Asthma Supportive Products, and provision of additional education to the member between visits if needed (billable to 24 units cap for ASME Home Visits).

Specifications for each visit are as follows:

- Initial Visit: must be conducted in-person or via video call in the member's dwelling to provide initial asthma and home environmental assessments and ensure appropriateness of Asthma Remediation services. The initial visit must identify member/caregiver knowledge, skills, and needs related to asthma, determine asthma control status by administrating and scoring a validated, age-appropriate asthma control Screening questionnaire (ACT, C-ACT, TRACK), and identify and provide education on home environmental factors/triggers potentially impacting asthma

- For the remainder of this Waiver period, if an ASME provider cannot be identified to conduct the Initial Visit in-person, the visit may be conducted virtually face-to-face (e.g., video call).

- Final Visit: may be conducted in-person in the member's dwelling or face-to-face virtually (e.g., video call) and must be no earlier than 45 days post completion of all Asthma Remediation services. In the rare circumstance where the member does not allow a final face-to-face visit in-person or virtually, the final visit may be conducted telephonically. The final visit must include asthma and home environmental post-assessments, administration and scoring of a validated age-appropriate asthma control Screening questionnaire (ACT, C-ACT, TRACK) to determine changes in asthma control status, reinforcement of ASME education, and reporting on member's progress and improvements in the home environment

The Social Care Navigator should make referrals if necessary for the member or their family if applicable before the Asthma Remediation service duration period ends.

Dwelling Assessment & Scope of Work (SOW) Development (including SOW Technical Review) (part of 2.3b):

- *Dwelling Assessment & SOW Development*: A comprehensive dwelling assessment of the primary residence to identify Home Remediations needed to reduce or eliminate asthma triggers and improve the indoor environment of the dwelling. Assessment should be conducted by a qualified home improvement contractor with industry-standard credentials in building science and healthy homes principles and incorporate results and relevant environmental findings from the initial ASME visit. The SOW should outline recommended remediation services, supportive products, and associated pricing based on the assessment. Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project.

- *SOW Technical Review:* Each SOW Technical Review must be conducted by a qualified reviewer with industry-standard credentials in building science and healthy homes principles working independently of the HRSN service provider for component c. "Home Remediation and Provision of Supportive Products". The SOW Technical Reviewer should ensure clear indication within the SOW when recommended services are considered to be invasive and return the SOW to Social Care Navigator. If the SOW includes invasive measures, written approval from the property owner (landlord in case of a rental) is required before beginning work (approval must be obtained by either the Social Care Navigator or provider of component c. Home Remediation and Provision of Supportive Products).

2.3b Asthma Remediation and Supportive Products: Installation services and supportive products may address ventilation and air quality, removal of asthma triggers, and Integrated Pest Management (IPM). Remediation services and supportive products will be limited to those listed in the table below and which are recommended in the SOW and approved by the Social Care Navigator after component b.2 SOW Technical Review. Member written approval is required to begin installation of approved SOW services. Remediation service providers must provide proof of credentials/licensure/industry-accepted certifications and training (including advanced requirements for specialized services such as HVAC, IPM, mold remediation etc.) AND have experience identifying and remediating asthma-related home environmental triggers. Total costs of services for Asthma Remediation may not exceed per member cap listed in the HRSN Fee Schedule for duration of Waiver period.

QA Inspection: Within 90 days of service completion, a QA Inspection should be conducted in alignment with Building Performance Institute (BPI) and other industry technical standards for QA for a minimum of 10 percent of households where Asthma Remediation services are provided by the SCN. QA provider should be

independent of provider of component c. Home Remediation and Provision of Supportive Products. If a QA Inspection identifies any issues with the work completed, the Social Care Navigator should work with the HRSN service provider to ensure work passes the QA Inspection.

Table 5-25: Remediation services and supportive products include the provision of:

Asthma Trigger Remediation Services	Asthma Supportive Products
Indoor Air Quality	Asthma Friendly Cleaning Supplies
Provision of: • Installation of air conditioner • Ventilation system upgrades / installation / repair • Whole-house fan • Heating unit clean and tune, repairs, or replacement • Forced air-furnace filter replacement and provision of (6) additional filters • Installation / repair of exhaust fan (kitchen and bathroom) • Dryer venting and cleaning • Air duct maintenance • Carpet steam cleaning • Insulation • Air sealing • Replacement of air filters in HVAC system	Provision of: • Hygrometer (Humidity gauge) • Microfiber cleaning cloths • Green scrubbers • Cleaning buckets and spray bottle • Microfiber mop • Castile soap • Cleaning vinegar (with recipe for mixing)
Mold Remediation and Moisture Control	Indoor Allergen Reduction
Provision of: • Plumbing repairs to support moisture control and water damage • Repairs to boilers (steam and water) • Repairs to condensate drain • Basement water proofing (coatings, drainage systems) • Sump pump repair / replacement • Carpet removal or removal of moldy wet flooring and installation of Asthma-friendly flooring • Dirt floor vapor barrier basement / crawlspace • Cleaning / repair / installation of gutter downspout system and gutter screens • *Mold remediation (less than or equal to 10 square feet) • *Mold remediation (greater than 10 square feet)	Provision of: • Vacuum with HEPA filter and filter replacements • Allergen impermeable pillow and mattress encasement
Integrated Pest Management (IPM)	
Provision of: • Sealing or patching cracks or openings in walls, baseboards, and around plumbing	

Asthma Trigger Remediation Services	Asthma Supportive Products
• Application of environmentally friendly pesticides, baits, and traps (use away from children and according to manufacturer's instructions) • Airtight food storage containers	

**Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments*

~~Air conditioners, humidifiers and air filtration devices (limited to mechanical only) will be available to members eligible for Asthma Remediation. These services will be funded under 2.2 Home Remediation Services subject to per-member caps. Members that are eligible for Asthma Remediation are automatically eligible to receive services under 2.2.a Home Remediation Services: Mold and Pest Remediation and 2.2b Home Remediation Services: Ventilation Improving Systems without a provider attestation.~~

Members that are eligible for referral to 2.3 Asthma Remediation automatically qualify to receive referral for 2.2a Home Remediation Services: Mold and Pest Remediation and 2.2b Home Remediation Services: Ventilation Improving Systems without a provider attestation.

Members may be separately assessed and deemed eligible by a Social Care Navigator for additional services under 2.1 Home Accessibility and Safety Modifications.

Table 5-26: Asthma Remediation: Eligibility and service details

Asthma Remediation: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14; 2. Meets the clinical criteria in Table 5-15, documented by a member indicator for "Uncontrolled Asthma" on the ESMF or provider attestation; and 3. Eligible Medicaid Managed Care member must be a resident of a single-family or multi-unit primary residence owned or rented by the member or a primary caregiver
Service Limitations and Restrictions	1. Social Care Navigator must document the source for confirmation of qualifying clinical criteria for Asthma Remediation as the ESMF or provider attestation in the member's Social Care Plan. 2. Asthma trigger remediation services and supportive products are limited to those that are of direct medical or remedial benefit to the Medicaid Managed Care member. 3. Asthma remediations must be conducted in accordance with applicable state and local building codes. 4. Prior to service delivery, the Social Care Navigator should collect documentation which verifies the member's address. • Members who own their home are required to submit the following:

Asthma Remediation: Eligibility and service details	
	○ Proof that homeowner owns the home: deed of home, property tax statement, OR mortgage documentation including homeowner's name and address • If the member does not own their home, the member will be required to submit: ○ Proof that member resides in the home: lease or rent-owed form or utility bill from the past 90 days OR ○ Any of the documentation under homelessness criteria that includes member address, as listed in Table 5-16 5. Services requiring invasive measures will require written approval from property owner (landlord, if the residence is rented). • Property owner will also need to provide proof of homeownership through one of the following: deed of home, property tax statement, OR mortgage documentation including homeowner's name and address 6. Eligible Medicaid Managed Care member must be a resident of a single-family or multi-unit primary residence owned or rented by the member or a primary caregiver. 7. Total costs of services for Asthma Remediation, including Dwelling Assessment & SOW development, SOW Technical Review, Home Remediation Service and supportive products, and QA Inspection, as needed, may not exceed per member cap listed in the HRSN Fee Schedule for duration of Waiver period. 8. The ASME provider may need to provide additional education to the member in-between Initial visit and Final visit. This time must be billed under the 24 units cap for ASME Home Visits.
Allowable Providers	1. Contracted Asthma Remediation service providers that are designated as a non-profit community-based organization 501 (c)(3) or 501(c)(4). 2. Asthma Remediation services may be performed by a contracted for-profit organization at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) community-based organization. See HRSN Network Capacity and Access section for details. 3. Asthma Self-Management Education (ASME) must be provided by a qualified nonphysician health care professional, such as a certified asthma educator specialist (AE-C), respiratory therapist (RT), or specially trained lay health worker (e.g., health educator, community health worker (CHW), etc.), with documented training and demonstrated competency in delivering guidelines-based Asthma Self-Management Education and comprehensive home environmental assessments to identify and provide education on reducing asthma triggers.

Asthma Remediation: Eligibility and service details	
	4. Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a New York State Contractor's License. 5. IPM services which include pesticide application must be delivered by professionals licensed by the NYS Department of Environmental Conservation. 6. HRSN service providers completing ~~Home Accessibility and Safety Modifications~~Asthma Remediation Services must have proof of credentials/licensure/industry-accepted certifications and trainings AND demonstrated experience providing Home Modifications Component b.1 Dwelling Assessment and SOW Development must be conducted by a qualified home improvement contractor with proof of industry-standard credentials in building science and healthy homes principles. 7. Component b.2 SOW Technical Review and component d. QA Inspection must be conducted by a qualified reviewer/inspector holding industry-standard credentials in building science and healthy homes principles working independently of the HRSN service provider for component c. "Home Remediation and Provision of Supportive Products". 8. HRSN service providers offering component c. Home Remediation and Provision of Supportive Products must have proof of credentials/licensure/industry-accepted certifications and trainings (including advanced requirements for specialized services such as HVAC, IPA, mold remediation, etc.) AND demonstrated experience providing home installation improvement services including identifying and remediating asthma-related home environmental triggers. 9. HRSN service providers must consult with the member's locality for any required permits prior to beginning invasive measures listed within the SOW

Workflow for Asthma Remediation Services: The SCN Lead Entity will need to create a unique workflow for Asthma Remediation services given the multiple service components of Asthma Self-Management Education, dwelling assessment, and associated Statement of Work (SOW) requirements, Home Remediation and Provision of Supportive Products, and QA Inspections. Note: Members that are eligible for referral to 2.3 Asthma Remediation automatically qualify to receive referral for *2.2a Home Remediation Services: Mold and Pest Remediation* and *2.2b Home Remediation Services: Ventilation Improving Systems* without a provider attestation.

In general, the workflow should follow the below steps (*see Figure 5-8 for a visual process flow*):

1. If the member is eligible for 2.3 Asthma Remediation services (and therefore automatically 2.2.a and 2.2.b), the Social Care Navigator will refer to an ASME provider to complete Asthma Remediation component a.
2. The ASME provider (component a.) will contact the member to schedule the initial ASME visit. After completion of the initial ASME visit under component a., the ASME provider will report the

recommended Enhanced HRSN services back to the Social Care Navigator and update the SCN IT Platform demonstrating the initial ASME services have been completed.

3. The Social Care Navigator reviews the HRSN service provider's findings and recommendations and confirms completion of initial ASME visit criteria. The Social Care Navigator then proceeds with securing a HRSN service provider to conduct component b.1.
4. The HRSN service provider for component b.1 will conduct the Dwelling Assessment and SOW Development and provide the SOW to the Social Care Navigator via the IT Platform. Only one Dwelling Assessment and SOW is required. The provider that conducts the Dwelling Assessment and develops the SOW can be reimbursed for admin time, including travel.
5. The Social Care Navigator will submit the SOW for Technical Review (component b.2.) to a qualified reviewer holding industry-standard credentials in building science and healthy homes principles working independently of the HRSN service provider for component c. Home Remediation and Provision of Supportive Products.
6. The provider for b.2 conducts the SOW Technical Review, indicates within the SOW which services involve invasive measures, and returns the SOW to the Social Care Navigator.
7. The Social Care Navigator conducts a review of the SOW to ensure all proposed measures are allowable since the HRSN service provider may recommend services that are not covered under the Enhanced HRSN Services. The total cost for Asthma Remediation services must be at or below the allowable cap amount in the HRSN fee schedule. If above the allowable cap, Social Care Navigator must in consultation with the Technical Reviewer (component b.2), prioritize the appropriate services to authorize for the member. The Social Care Navigator must enter and create unique referrals for each service included in the approved SOW and document authorized services within the Social Care Plan.
8. The Social Care Navigator must ensure member written approval of approved SOW services to begin remediation services. Any SOW involving invasive measures, as confirmed by the SOW Technical review, also requires written approval from the property owner (landlord if the residence is rented).
9. The Social Care Navigator makes referral to HRSN service provider for component c. Remediation service providers for component c. and/or their subcontractors must provide proof of credentials/licensure/industry-accepted certifications and training (including advanced requirements for specialized services such as HVAC, IPM, etc.) AND have experience identifying and remediating asthma-related home environmental triggers. The HRSN service provider or subcontractor of component c. proceeds with completing Home Remediation and Provision of Supportive Products as approved in the SOW. The HRSN service provider for component c. Home Remediation and Provision of Supportive Products may be the same or different entity for component b.1. Dwelling Assessment & SOW Development.
10. Provider of component c. completes Home Remediation Service and Provision of Supportive Products.
11. For a minimum of 10 percent of households where Asthma Remediation services are provided (as determined at the discretion of the SCN Lead Entity), component d. QA Inspection should be conducted by a qualified inspector holding industry-standard credentials in building science and healthy homes principles, within 90 days of completion of component c. Provider of component d. Quality Assurance (QA) Inspection must be independent of the HRSN service provider for component c. Home Remediation and Provision of Supportive Products. If a QA Inspection identifies any issues with the work completed,

the Social Care Navigator should work with the HRSN service provider to ensure work passes the QA Inspection.

12. The HRSN service provider of component c. updates the SCN IT Platform to demonstrate the services have been completed. The Social Care Navigator notifies the ASME provider (component a.) of the completion of services under component c.
13. The ASME provider (component a.), follows up with the member to schedule and conduct the final ASME visit 45 days after Asthma Remediation services have been completed. The ASME provider updates the SCN IT Platform to demonstrate the final services under component a. have been completed.
14. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the member within 5 business days to document their satisfaction.

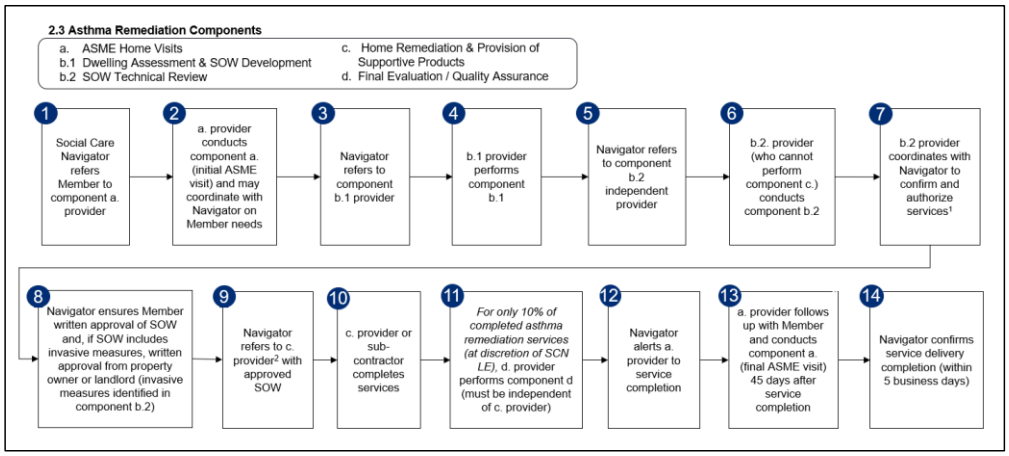
Note: If the cost of services is $2,000 or more, the HRSN service provider must either:

a. Obtain at least three bids for any total work of $2,000 or more and select the lowest price and best value or substantially equivalent bid, if applicable. ~~Bid solicitation for a specific SOW occurs after the SOW is approved (during step 9 in the outlined workflow). (~~As a last resort, the SCN Lead Entity may move forward with only two bids if there is limited capacity within SCN region.

b. If preferred, the SCN Lead Entity can establish a list of preferred contractors through a competitive bidding process to be updated annually, and the HRSN service provider can select a contractor for recommended modifications from this list without soliciting at least 3 bids for each service.

Across both options, bid development (e.g., time spent traveling to the site, writing up the bid) will not be reimbursed.

Figure 5-8: Process flow for Asthma Remediation services



[1]Contracted Network organization may suggest services that are not covered under the SCN Lead Entity Enhanced HRSN Services. SCN Lead Entity may authorize ONLY the approved Enhanced HRSN Services

[2]Refer to bidding process in workflow above

2.4 Recuperative Care (Medical Respite)

Recuperative Care (Medical Respite) is temporary residential care and supportive services provided to homeless or unstably housed members who do not have an acute need to be hospitalized but require health care services and supports to continue to recover from an illness or prepare for a medical procedure. Services include short-term residential care that allow homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. Recuperative Care will be provided in the form of short-term pre-procedure and post-hospitalization service by NYS-certified Medical Respite Programs (MRPs) and in accordance with New York State's established Medical Respite regulations (10 NYCRR Part 1007) and program guidance. Post-hospitalization stay is available for up to 90 days per year (assessed on a rolling basis). Pre-procedural care is based on the provider's directions but cannot exceed 30 days per year. Certified MRPs must also offer transitional supports to help members secure stable housing and avoid future hospital readmissions, coordinate with the SCN Lead Entity to offer additional Enhanced HRSN Services to the member when applicable, such as transitional Housing Navigation services, Nutrition supports, Transportation, and Care Management services prior to the member's discharge date from the Medical Respite. For further information about NYS-certified Medical Respite Programs (MRPs) please visit:
https://www.health.ny.gov/health_care/medicaid/redesign/sdh/respite.htm

Recuperative Care may be used as:

a. *Short-term Post-Hospitalization Care:* provided to eligible members transitioning out of institutions or acute care hospitals in which a Social Care Navigator may also consider this population eligible under Medicaid High Utilizer, and who are at-risk for incurring other Medicaid state plan service costs, such as for inpatient hospitalizations or Emergency Department visits to receive treatment on a short-term basis. Need for short term post-hospital care must be indicated in the member's facility discharge and MR referral documents. Following an Eligibility Assessment, the Social Care Navigator will determine whether the member meets social and clinical criteria for the service.
b. *Short-term Pre-Procedure Care:* provided to eligible members that are experiencing homelessness and are scheduled for a medical procedure or surgery that has been indicated as needing preparation or pre-surgical care by a medical professional. Referral should document the need for pre-procedure care and the anticipated length of stay.

Table 5-27: Recuperative Care (Medical Respite): Eligibility and service details

Recuperative Care (Medical Respite): Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14, including meeting the HUD definition of homeless or at-risk of homelessness, and 2. Meets the clinical criteria in Table 5-15 (as indicated in the referral package or via provider attestation).
Service Limitations and Restrictions	1. Individual must be assessed for Medical Respite program eligibility and appropriateness in accordance with MR regulations and guidance

Recuperative Care (Medical Respite): Eligibility and service details	
	2. Post-Hospitalization Recuperative Care may be offered for up to ninety (90) days in duration once every 12 months (assessed on a rolling basis) 3. Pre-procedure stays are limited to a clinically appropriate amount of time as determined by medical professional but cannot exceed 30 days per year. 4. Eligible settings for Recuperative Care (i.e., short-term Pre-Procedure and Post-Hospitalization) must have staffing sufficient in number and qualification to render all required Medical Respite services in accordance with the NYS established Medical Respite regulations (10 NYCRR Part 1007) and relevant program guidance
Allowable Providers	1. State-certified Medical Respite providers who are contracted with the SCN Lead Entity

Workflow for Medical Respite Service: The SCN Lead Entity will need to create a unique workflow for the contracted Medical Respite provider due to the requirements that (1) the member will first have an Eligibility Assessment with the Social Care Navigator and (2) the eligible member will have a secondary assessment conducted by the Medical Respite facility in accordance with their regulatory requirements (*see Figure 5-9 for a visual process flow*). Medical Respites will have the option available to have unique user roles to complete additional Social Care Navigator responsibilities (e.g., Screening, Navigation, Eligibility Assessment), but they are not required to.

1. Hospitals, clinics, HRSN service providers, and ecosystem partners will send the member's referral for Medical Respite Program (MRP) services directly to the regional SCN Lead Entity, without HRSN Screening or Eligibility Assessment *(See below for elements that must be included in this referral)*
2. Social Care Navigators should prioritize MRP referrals and strive for a rapid turnaround of 2 business days to outreach the member to complete Screening and Eligibility Assessment. The Social Care Navigator will conduct Screening and Eligibility Assessment with the member (if not already completed by the referring entity). The clinical criteria required per NYHER can be sourced from the referring entity's referral package.
3. Based on the Social Care Navigator's Eligibility Assessment, the SCN's Social Care Navigator will either:
    a. **Reject the referral**
    If the Social Care Navigator determines the member is not NYHER eligible after the Eligibility Assessment, they will directly inform the member or authorized representative live.~~if the member does not meet NYHER eligibility criteria.~~ The SCN IT Platform will have the ability to record the rejection as from the Social Care Navigator. The Social Care Navigator will notify the referring entity of the rejection **OR;**
    b. **Accept the referral**
    If the Social Care Navigator determines the member meets NYHER eligibility criteria, they will directly inform the member or authorized representative live. The Social Care Navigator will then refer the member to a local contracted MRP for their regulatory assessment *(For timing requirements, see HRSN capacity and access guidelines and requirements.)*
4. The MRP will then conduct their regulatory assessment which may be in person in accordance with the NYS established regulations and MRP guidance. The MRP will work towards accepting the referral within

the number of days listed in Section ii. HRSN capacity and access guidelines and requirements. Based on the MRP regulatory assessment, the MRP will either:

a. **Reject the SCN's referral.** If the MRP rejects the Social Care Navigator's referral in the platform (due to capacity, individual is not appropriate for facility, etc.), the Social Care Navigator will either initiate a referral to another MRP that may accept the member. When attempts have been exhausted, the Social Care Navigator will verbally notify the referring entity and the member or their authorized representative of the unsuccessful attempts to find an appropriate MRP. The SCN IT Platform will ~~have the ability of recording~~record the rejection as coming from the MRP; **OR**

b. **Accept the SCN's referral.** If the MRP accepts the member's referral, the MRP will determine an appropriate length of stay. The MRP will proceed with SCN IT Platform requirements to accept the Social Care Navigator's referral request

5. The Social Care Navigator notifies the referring entity that the MRP accepts the referral
6. The Social Care Navigator documents the referred MRP services within the member's Social Care Plan which will include start date, service duration, indication of pre- or post-respite stay and pre-determined date to follow up with the member on any other recommended Enhanced HRSN services
7. The MRP reviews and uploads to the SCN IT platform documentation verifying the member's homelessness status, if applicable
8. The MRP proceeds with rendering their services, documents relevant notes into the SCN Social Care Plan including estimated discharge date in the SCN IT Platform
9. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the member / MRP to document the member's satisfaction. The SCN will work closely with the MRP and offer collaborative assistance with care coordination including additional transitional HRSN services prior to the discharge date (where the member qualifies for additional Enhanced HRSN Services)
10. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the MRP on the HRSN fee schedule-based reimbursement basis
11. The SCN Lead Entity proceeds with issuing a completed Social Care Claim to the MCO for completed service (for tracking purposes only)

Medical Respite's Regulatory Assessment

The referring entity's (Hospitals, clinics, HRSN service providers, and ecosystem partners) referral package sent to the Social Care Navigator will be used to support the Medical Respite's regulatory assessment which is conducted solely by the Medical Respite provider. The clinical criteria required per NYHER may be sourced from the referring entity's referral package. However, only the Medical Respite provider can determine if the member is appropriate to receive Medical Respite services and will not be assessed by the Social Care Navigator.

Referral Package

A referral from an originating entity (e.g., hospitals, clinics, etc.) to the SCN Lead Entity must include all of the following:

Basic demographic and identifying information, such as:

1. Name;
2. Date of birth;
3. Social security number (if available);
4. Copies of any available government-issued documentation (such as driver's license, non-driver ID, or immigration papers); and
5. Health coverage status (including a copy of any pending application for coverage, if applicable).
6. Indication of NYHER Eligibility for Medical Respite:
    - Homelessness or at-risk of homelessness
    - Pre-procedure:
        - Requiring pre-surgical or pre-procedure care as indicated by a medical professional and recommended length of stay, **or**
    - Post-hospitalization:
        - ~~Admission or discharge~~ Transitioning from an institution or acute care hospitalization related to a health condition or illness, **and**
        - Requiring recuperation and care for an illness or injury, **and**
        - At-risk for incurring other Medicaid state plan services, such as inpatient hospitalization or Emergency Department visits

NOTE: Medical orders and medical records should be coordinated between referring entity and the Medical Respite directly, as SCNs may not receive such documentation.

Medical orders (coming from original referring entity, not the SCN) for items that the individual will need for recuperation, such as:

- 30-day supply of medication(s), either by submitting prescription(s) to a pharmacy or arranging to transfer the medication(s) with the recipient;
- Home health care service orders (if applicable); and
- Durable medical equipment or other supplies (if applicable).

Medical records that address:

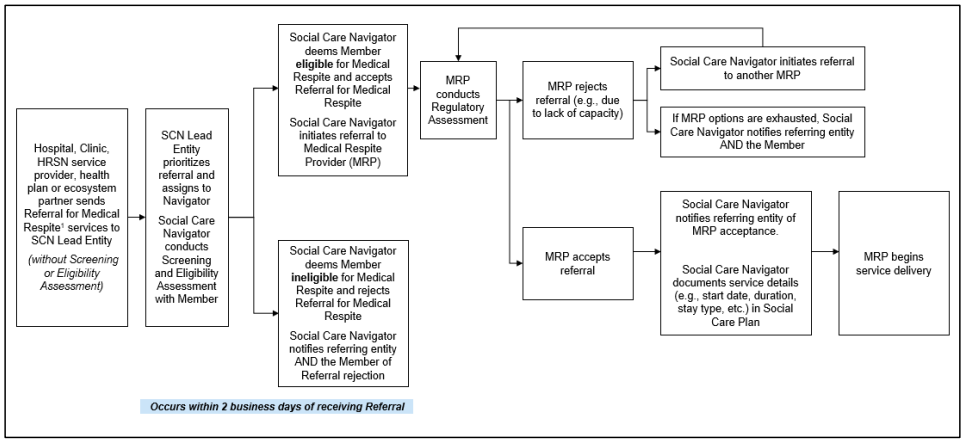
- The individual's diagnosis;
- Pertinent medical history;
- Results of diagnostic tests or Screenings; and
- Current or recommended interventions, including post-acute care and medications

The referring entity's referral package may be communicated in the form of medical records and/or narrative explanations, and/or a referral form and must include all of the following:

- Information to support the provider's conclusion that the individual is experiencing homelessness or at-risk of homelessness, including the individual's current living situation or situation prior to being admitted to a facility;
- Description of the individual's physical limitations, if applicable, and any reasonable accommodations that may be required of the Medical Respite program;
- Confirmation that the individual can perform ADLs with no or minimal assistance *or* provision of a physician order for certified home health agency services;

- Confirmation that the individual is self-directing *or* receives at least part-time supervision from a self-directing individual or entity that is responsible for making decisions related to the individual's ADLs;
- Confirmation that the individual is not, at the time of referral, a threat of harm to their self or others

Figure 5-9: Process flow for Medical Respite services



[1]Referral must include: a) Basic demographic and identifying information, b) Eligibility Assessment of individual to receive Medical Respite services and c) Medical orders and medical records ~~cannot be sent directly to the SCN Lead Entity, but coordinated between the originating referring entity and the MRP.~~

2.5 Rent / Temporary Housing (Rental Subsidy and Back Rent)

Rent / Temporary Housing (Rental Subsidy and Back Rent) includes payment for rent for up to six months. Payment for Housing services (e.g., rent payments) must not be paid directly to a member. The SCN must identify the ~~provide payment to the~~ Housing provider (e.g., HRSN service provider, housing management agency, landlord) to receive rent payments and coordinate directly with them. Rental subsidy can only be paid to the landlord listed on the lease or TCO. Rental Subsidy and Back Rent may be used for a. Permanent / Long Term Housing or b. Temporary / Transitional Housing.

a. Permanent/Long-Term Housing includes: rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes, manufactured home lots, or motel or hotel when it is serving as the member's primary residence (back rent only).

- If a member is experiencing IPV in their household, is homeless or at-risk of homelessness and is part of the Enhanced Population, then Social Care Navigators can permit reimbursement (towards the 6-month service duration) for a member to stay in a motel/hotel as a temporary solution. For this service to be successful, the Social Care Navigator must ensure there is a plan in place with the member and housing provider to begin efforts towards permanent, long-term housing or transitional housing programs through utilization of 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services and/or 2.10 Housing Transition and Navigation Services. Back rent can be used when a member meets the HUD definition of

homeless or at-risk of homelessness (Table 5-14). Eligible costs include rental payments up to the U.S. Department of Housing and Urban Development (HUD) Fair Market Rate (past-due or forward rent, landlord-paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments).

b. Temporary/Transitional Housing includes: transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming.

For the coordination of the Rent / Temporary Housing service, members should also be referred to one of the following Enhanced HRSN services: 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services. The services of 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services and 2.10 Housing Transition and Navigation Services include both member and non-member facing coordination and can be billed as follows:

1. HRSN service providers' housing service coordination time should be billed under the applicable 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services.

2. Coordination can also be covered under Enhanced Care Management if the coordination is performed by a Social Care Navigator and reimbursement requirements set forth in Section 5.C.ii Reimbursement for Social Care Navigation are met.

Table 5-28: Rent / Temporary Housing (Rental Subsidy and Back Rent): Eligibility and service details

Rent / Temporary Housing: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14, including meeting the HUD definition of homeless or at-risk of homelessness, and 2. Meets the clinical criteria in Table 5-15.
Service Limitations and Restrictions	1. Rent / Temporary Housing (Rental Subsidy and Back Rent) services are limited to up to six months for the duration of the Waiver. The Social Care Navigator must ensure that the member is connected to other programming or permanent housing through available local, state, and federal programs by the end of the six-month period 2. Social Care Navigators must assess whether member meets homelessness criterion and document in the Social Care Plan if a member is homeless or at-risk of becoming homeless as defined by the U.S Department of Housing and Urban Development (HUD) along with clinical criteria as defined in Table 5-15. 3. Rent / Temporary Housing (Rental Subsidy and Back Rent) services are limited to those eligible members who are willing and capable of living safely within community with appropriate and cost-effective support services. Social Care Navigators must document this in the eligible member's Social Care Plan 4. The size of the unit must follow household guidance as outlined in Table 5-6 *(see Considerations for children, youth, and households section for details*) 5. The goal of this service is to ensure members are placed into a permanent, long-term housing or transitional housing programs. The service should not be used to

Rent / Temporary Housing: Eligibility and service details	
	place members in temporary living arrangements (e.g., hotel, motel when not main residence) that would otherwise expire after the duration of this service and result in an unstable housing situation for the member. As part of evaluation under 2.7 Pre-Tenancy Services, Members should not be placed in rental units that would not be reasonable for them to financially maintain beyond their service support duration. Social Care Navigators should connect to available services to support member readiness and to proactively address circumstances that may jeopardize housing (e.g., tenancy sustaining, financial planning). In addition, eligible members can be referred to an EESHI housing provider or a Medicaid Redesign Team (MRT) housing provider for rental subsidy and support ~~under MRT contract~~. (See section 5.k.Partnerships for more details). 6. Prior to service delivery, the Social Care Navigator should collect and upload documentation to the SCN IT platform which verifies the member's address and the landlord's information. Acceptable proof of residence includes a lease, a rent-owed form, a utility bill issued within the past 90 days or any of the documentation under homelessness criteria that includes member address, as listed in Table 5-16. The HRSN service provider should review and upload documentation to the SCN IT platform verifying the member's homelessness status, if applicable
Allowable Providers	1. Contracted community-based housing service providers, with experience serving populations eligible for Enhanced HRSN Services and are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted Rent / Temporary Housing (Rental Subsidy and Back Rent) services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. (*See HRSN Network Capacity and Access section for details)* 3. Housing service providers must have knowledge of principles, methods, and procedures of Housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.6 Utility Setup / Assistance

Utility Setup / Assistance is limited to members receiving Rent / Temporary Housing (Rental Subsidy and Back Rent) service per **Section 2.5: Rent / Temporary Housing** (Rental Subsidy and Back Rent) above. Qualified members may be eligible for assistance with setting up utility services in their new community living setting. Utility Setup / Assistance services may include one-time activation costs, back payments to secure utilities, and payment of up to six (6) months of utility costs.

This service provides payment for recurring utilities costs for up to six (6) months. Eligible members may receive a one-time payment assistance with utility activation fees and/or back payment up to a capped amount, as listed in the HRSN Fee Schedule. Payment for utility services should not be paid directly to a member. The SCN should provide payment to the utility provider (e.g., electric company, internet provider, recycling service) directly. This service will cover expenses for the following types of utility payments:

- Garbage
- Water
- Sewage
- Recycling
- Gas/oil
- Electric
- Internet
- Phone (inclusive of landline phone service and cell phone service)

For the coordination of the Utility Setup / Activation service, members should be referred to one of the following Enhanced HRSN services: 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services. HRSN service providers' housing service coordination time should be billed under the applicable 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services. Coordination can also be covered under Enhanced Care Management if the coordination is performed by a Social Care Navigator and reimbursement requirements set forth in Section 5.C.ii Reimbursement for Social Care Navigation are met.

- *Utility Activation:* Provides payment for non-refundable, non-recurring utility set-up costs or restart costs if the service has been discontinued.
- *Utility Back Payments:* Provides one-time payment, up to a capped amount, for utility back payments
- *Utility Assistance:* Covers up to 6 months of utility costs

Table 5-29: Utility Setup / Assistance: Eligibility and service details

Utility Setup / Assistance: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14, including meeting the HUD definition of homeless or at-risk of homelessness, and 2. Meets the clinical criteria in Table 5-15 3. Must be receiving Rent / Temporary Housing (Rental Subsidy and Back Rent) services as described in Section 2.5 on Rent / Temporary Housing (Rental Subsidy and Back Rent)
Service Limitations and Restrictions	1. Utility Setup / Assistance is limited to up to 6 months per demonstration period 2. Utility activation fees and/or back payment is limited to a one-time payment assistance, up to a capped amount. 3. Utility Setup / Assistance is limited to individuals receiving Rent / Temporary Housing (Rental Subsidy and Back Rent) services as outlined in Section 2.5. Individuals should not receive coverage of utility activation costs under both 2.6 Utility Setup / Assistance and 2.8 CTS 4. Prior to service delivery, the Social Care Navigator should collect and upload documentation to the SCN IT platform which verifies the member's address. Acceptable proof of residence includes a lease, a rent-owed form, a utility bill issued within the past 90 days or any of the documentation under homelessness criteria that includes member address, as listed in Table 5-16. The HRSN service provider should

Utility Setup / Assistance: Eligibility and service details	
	review and upload documentation to the SCN IT platform verifying the member's homelessness status, if applicable.
Allowable Providers	1. Contracted Utility / Set-up service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501 (c)(3) or 501(c)(4). non-profit organization 2. Contracted Utility / Set-up services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. *(See HRSN Network Capacity and Access section for details)* 3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.7 Pre-Tenancy Services

Under this service, Social Care Navigators can help determine sustainable housing options based on a member's eligibility and work with the member towards securing an approved housing application. Once a housing application is approved, the Social Care Navigator can explore rent or back payments under 2.5 Rent/Temporary Housing. Medicaid Managed Care members may qualify for Pre-Tenancy Services under this 1115 Waiver authority, for up to 6 months. These services include:

- Assistance with navigating the complexities of the housing application and supporting the member when undergoing tenant Screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews
- Assistance with the housing search and application process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance

Members with approved housing applications should also be referred to the following Enhanced HRSN services: 2.5 Rent/Temporary Housing, 2.9 Tenancy Sustaining Services and 2.10 Housing Transition and Navigation Services.

The services of 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services and 2.10 Housing Transition and Navigation Services include both member and non-member facing coordination and can be billed as follows:

1. HRSN service providers' housing service coordination time should be billed under the applicable 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services.

2. Coordination can also be covered under Enhanced Care Management if the coordination is performed by a Social Care Navigator and reimbursement requirements set forth in Section 5.C.ii Reimbursement for Social Care Navigation are met.

Table 5-30: Pre-Tenancy Services: Eligibility and service details

Pre-Tenancy: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14, including meeting the HUD definition of homeless or at-risk of homelessness, and 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Services are limited to no more than six months. 2. If applicable, prior to service delivery, the HRSN service provider should review and upload to the SCN IT platform documentation verifying the member's homelessness status.
Allowable Providers	1. Contracted Pre-Tenancy housing service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted Pre-Tenancy housing services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. (*See HRSN Network Capacity and Access section for details)* 3. Housing services providers must have knowledge of principles, methods, and procedures of Housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.

2.8 Community Transitional Supports (CTS)

Services are intended to assist members who have secured a new housing unit to have a smooth and seamless transition to community living. Member must be assessed and their need for any of the following services should be documented in the Social Care Plan. Assistance with the set-up of the new housing unit and review of the living environment to ensure that it meets the member's clinical, furnishings, adaptive aids, environmental modifications, and food and clothing needs at transition. Total costs of services may not exceed per member cap listed in the HRSN fee schedule for duration of Waiver period. The following one-time transition and moving costs are included:

- Security deposit and brokerage fees;
- Utility activation fees, movers, and relocation expenses;
- Pest eradication and inspection fees;
- Pantry stocking food (limited to a maximum of 30 days of food); and
- The purchase of household goods and furniture. Covered furnishings are limited to:
  a. Living Room
    - Couch/ loveseat/ recliner
    - Table
    - Lamp
  b. Kitchen
    - Table and chairs

- Countertop microwave
- Garbage pail
- Kitchen kit: pots, pans, utensils, dishes, dish soap, dishtowels
- Coffee Pot
- Toaster (not oven)

c. Bathroom

- Bathroom kit: bath towels, wash cloths, hand towels, mats for floor and bathtub, basic toiletries including toothbrush, hairbrush or comb, and initial purchase of soap, shampoo, conditioner, toothpaste, and toilet paper
- Toilet plunger
- Tension rod
- Shower curtain, liner, and rings
- Grab bar
- Handheld shower head

d. Other

- Secure medicine storage container
- Vacuum under $100
- Essential cleaning supplies
- Clock
- Blinds/ curtains
- Foldable shopping cart

e. Bedroom (per participant)

- Sheets and pillows
- Waterproof/vinyl mattress and pillow protector
- Bed (i.e., mattress, box spring, and frame; twin or full size)
- Comforter
- Chest of drawers
- Nightstand
- Lamp

It is the responsibility of the HRSN service provider to obtain receipts for ALL items purchased. Copies of receipts must be submitted to the SCN. For provision of security deposits, the HRSN provider should pay the security deposit directly to the landlord and follow the typical workflow for generating a claim.

For the coordination of the Community Transitional Supports service, members should be referred to one of the following Enhanced HRSN services: 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services. HRSN service providers' housing service coordination time should be billed under the applicable 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services. Coordination can also be covered under Enhanced Care Management if the coordination is performed by a Social Care Navigator and reimbursement requirements set forth in Section 5.C.ii Reimbursement for Social Care Navigation are met.

Table 5-31: Community Transitional Supports (CTS): Eligibility and service details

CTS: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14, including meeting the HUD definition of homeless or at-risk of homelessness, and 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Service does not continue after the individual is stably housed 2. Total costs of services may not exceed per member cap listed in the HRSN Fee Schedule for duration of Waiver period 3. Prior to service delivery, the Social Care Navigator should collect documentation which verifies the member's address. Acceptable proof of residence includes a lease, a rent-owed form, a utility bill issued within the past 90 days or any of the documentation under homelessness criteria that includes member address, as listed in Table 5-16. If applicable, prior to service delivery, the HRSN service provider should review and upload to the SCN IT platform documentation verifying the member's homelessness status. 4. If the HRSN service provider is a tax-exempt entity (e.g., 501(c)3), the HRSN service provider must ensure their purchases are tax-exempt. 5. Individuals should not receive coverage of utility activation fees under both 2.6 Utility Setup / Assistance and 2.8 CTS
Allowable Providers	1. Contracted community-based housing service providers, with experience providing Community Transitional Support services that are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted Community Transitional Support services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. (*See HRSN Network Capacity and Access section for details)* 3. Housing services providers must have knowledge of principles, methods, and procedures of Housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.9 Tenancy Sustaining Services

Medicaid Managed Care members may qualify for a range of services to assist in maintaining and sustaining their tenancy in affordable or supportive housing by providing tenant rights education and eviction prevention. Tenancy Sustaining Services are intended to assist members in securing housing and have a smooth and seamless transition to community living. Service is limited to 6 months, and members must be assessed and their need for any of the following services must be documented in the service plan. Under this Waiver authority, Tenancy Sustaining Services will include:

- Assistance in linking to free or affordable legal services for members facing housing-related issues;
- Connection to available resources to assist in establishing a bank account and paying bills;

- Assistance in connecting the member with social services to assist with filling out applications and appropriate documentation to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy;
- Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include direct interventions to address risks and connect the member to relevant community resources that may offer assistance;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions; and
- Assistance with housing recertification processes, including lease renewals and housing subsidy renewals

The services of 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services and 2.10 Housing Transition and Navigation Services include both member and non-member facing coordination and can be billed as follows:

1. HRSN service providers' housing service coordination time should be billed under the applicable 2.7 Pre-Tenancy Services, 2.9 Tenancy Sustaining Services or 2.10 Housing Transition and Navigation Services.

2. Coordination can also be covered under Enhanced Care Management if the coordination is performed by a Social Care Navigator and reimbursement requirements set forth in Section 5.C.ii Reimbursement for Social Care Navigation are met.

Table 5-32: Tenancy Sustaining Services: Eligibility and service details

Tenancy Sustaining Services: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Tenancy Sustaining Services does not include the payment of rent or other housing costs 2. Service is limited to six months
Allowable Providers	1. Contracted Tenancy Sustaining community-based housing service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501 (c)(3) or 501(c)(4) non-profit organization 2. Contracted community-based legal service providers, with experience serving the target population that are registered as a 501(c)(3) or 501(c)(4) CBO non-profit organization 3. Contracted Tenancy Sustaining housing services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. (*See HRSN Network Capacity and Access section for details)* 4. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.10 Housing Transition and Navigation Services

Medicaid Managed Care members may qualify for assistance navigating and transitioning into a new home, for 4 hours per month for up to 6 months and may be re-authorized up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services. As a guiding principle, services are not intended to be permanent solutions, and Social Care Navigators should work to connect members to more permanent resources (existing federal, state, and local services) where possible. Under this 1115 Waiver authority, Housing Transition and Navigation Services will include:

- Assistance with the set-up of a new housing unit, including clinically appropriate residential modifications, and identifying needs for assistance with arranging the move and supporting the details of the move, as appropriate;
- Connection to resources aiding with housing costs and other expenses; including linkages to rental assistance vouchers, security deposits, application fees, moving costs, etc.;
- Review of the living environment to ensure that it meets the clinical needs of the individual and is ready for move-in, including collaborating with the relevant provider staff where the individual is institutionalized (e.g., hospital or facility social worker) to ensure a seamless transition to the community

Table 5-33: Housing Transition and Navigation Services: Eligibility and service details

Housing Transition and Navigation Services: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14, including meeting the HUD definition of homeless or at-risk of homelessness, and 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Services are capped at 4 hours per month for up to 6 months and may be re-authorized up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services 2. If applicable, prior to service delivery, the HRSN service provider should review and upload to the SCN IT platform documentation verifying the member's homelessness status.
Allowable Providers	1. Contracted Housing Transition and Navigation service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted Housing Transition and Navigation Services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. (*See HRSN Network Capacity and Access section for details*) 3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

3. Nutrition

The NYS 1115 Waiver makes available several nutrition support services to meet the eligible Medicaid Managed Care member's needs. These nutrition supports are intended to provide timely access to adequate food resources that provide nourishment and help prevent adverse health and social impacts. All individuals at the end of the Enhanced HRSN Service duration will also be offered connection to WIC (DOH), SNAP (OTDA), and/or Older Americans Act nutrition services through Care Management services.

If a member is eligible for Nutrition service re-authorization as described in Section 5. Care Delivery Approach, part e. Service Re-Authorization, then the member may elect to receive a different type of Nutrition service for their 6-month reauthorization period if eligible and requested. For instance, a member may have received 6 months of Medically Tailored Meals and upon reauthorization, decide to opt for Pantry Stocking. However, if a member requests to change their Nutrition service in the middle of service period and before re-authorization, then the sum of the service duration already received must be subtracted from the max service duration allowed to determine the end date of the new Nutrition service

MLTCP and MAP members are not eligible for 1115 Waiver Nutrition services since they are provided as a plan benefit with the exception of Cooking Supplies.

Pregnant, postpartum individuals and high-risk children under 18 are eligible for additional MMC members within their household to also receive Nutrition supports where indicated.

Table 5-34: Food Security Screening questions

Food Security Screening questions	
1. Within the past 12 months, you worried that your food would run out before you got money to buy more	☐ Often true ☐ Sometimes true ☐ Never true
2. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more	☐ Often true ☐ Sometimes true ☐ Never true

In navigating members to Enhanced HRSN Services, Social Care Navigators should determine the type of Nutrition services that are appropriate for each member based on their unique needs and eligibility criteria. For members who are eligible for BOTH prepared meals (MTMs or clinically appropriate meals) and groceries (food prescriptions, food vouchers, or pantry stocking), the Social Care Navigator should ask the member the appropriate to determine the most appropriate service for the member (*see Eligibility Assessment Process for specific questions*).

3.1 Nutrition Counseling and Education

SCNs will provide Nutrition Counseling and Education services, including topics on healthy meal preparation and connecting the individual with grocery budget resources. Nutrition Counseling and Education will be provided by Certified Dietitian Nutritionists (CDN) / Registered Dietician Nutritionists (RDN), who will assess a member's nutrition needs based on age, activity level, and special circumstances resulting from medical conditions such as

diabetes, high blood pressure, food allergies, and obesity. This assessment will help plan for and direct the provision of food appropriate for physical and dietary needs, provide tailored nutrition counseling, such as advice on dietary changes, and plan menus and direct the preparation of food to meet dietary needs. Nutrition Counseling and Education may include the following examples for individuals or groups:

- Assessment of nutritional needs and food patterns (HRSN service provider should ensure the assessment in saved within the Social Care Plan);
- Planning for and directing the provision of food appropriate for physical and nutritional needs;
- Nutrition counseling; and
- Meal preparation and grocery shopping education

Referrals to Nutrition Counseling and Education and other Nutrition services are independent – Social Care Navigators may refer members to both Nutrition Counseling and Education and other Nutrition services at the same time. Nutrition Counseling and Education can be used as a standalone service or can be utilized in conjunction with other Enhanced HRSN Nutrition supports (e.g., provided as an added support to 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions). Nutrition Counseling and Education is not intended to be used as a pre-cursor referral to other Nutrition services since assessment and intake is already an aspect of services 3.2 and 3.3. OHIP expects that referrals to Nutrition Counseling and Education will be appropriate and beneficial for members receiving other Nutrition services. Social Care Navigators may determine whether these referrals should be made to the same or different HRSN service provider depending on member needs and the capabilities of HRSN service providers.

Table 5-35: Nutrition Counseling and Education: Eligibility and service details

Nutrition Counseling and Education: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14. 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Nutrition Counseling and Education must be approved by a CDN or RDN and be evidence-informed and 2. Be provided in accordance with evidence-based nutrition guidelines 3. Service is available for up to 6 months with possibility for re-authorization, up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services. As a guiding principle, services are not intended to be permanent solutions, and Social Care Navigators should work to connect members to more permanent resources (existing federal, state, and local services) where possible.
Allowable Providers	1. CDN or RDN 2. Nutrition services providers must have knowledge of principles, methods, and procedures of the Nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

3.2a Medically Tailored Meals

Home delivered prepared Medically Tailored Meals will be available to Medicaid Managed Care members who have an identified unmet HRSN for nutrition and meet specific eligibility requirements. Meal plans will be tailored to the medical needs of the member, approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN), and designed to improve health outcomes, lower cost of care, and increase member satisfaction.

Medically Tailored Meal providers must provide qualified individuals with medically appropriate meals designed to meet all of the member's medical nutrition requirements. Nutrition counseling must be available to members receiving medically tailored meals. Medically Tailored Meals benefit is designed to be tailored by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) to an individual member with a chronic condition[2] and/or pregnant or postpartum persons and must adhere to standards informed by established nutrition guidelines, such as the Food is Medicine Coalition (FIMC) MTM nutrition standards, for specific health conditions and tailored to member's health condition.

Medically Tailored Meals requires RDN / CDN involvement in two steps:

1. **Initial intake / assessment with the member**: The initial member intake / assessment must be approved by an RDN or CDN. Any employee of the HRSN service provider may conduct intake with the member, so long as an RDN or CDN reviews and signs off.
2. **Oversight and meal plan design:** An RDN or CDN must design and approve a member's medically tailored meals in order to ensure meals meet all of the member's medical nutrition requirements. RDN / CDN involvement and design of the meal plan is included in reimbursement rate for services.

MTM providers must have in-house RDN/CDNs to conduct this oversight and provide approvals.

Social Care Navigators should refer members to Nutrition services for the maximum duration and dose of the service. In general, OHIP expects this maximum duration and dose will be appropriate to address the HRSNs of most members. However, an HRSN service provider may determine in consultation with the member that a more limited duration and/or dose are more appropriate for the member's circumstances. The HRSN service provider should invoice the SCN Lead Entity for the actual quantity of service provided.

Table 5-36: Medically Tailored Meals: Eligibility and service details

Medically Tailored Meals: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14. 2. Cannot prepare their own meals *(see Eligibility Assessment Process for specific questions Social Care Navigator should ask member to make this determination)* 3. Meets the additional clinical criteria in Table 5-15 4. If an eligible member is a high-risk child under the age of 18, additional Medicaid Managed Care-enrolled individuals in the member's household may receive MTM

2 A full list of Eligible Chronic Conditions can be found here: Health Home Chronic Conditions (ny.gov)

Medically Tailored Meals: Eligibility and service details	
	regardless of if those individuals are part of an Enhanced Population. Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected 5. If an eligible member is pregnant or postpartum, additional Medicaid Managed Care-enrolled individuals in the member's household may receive MTM regardless of if those individuals are part of an Enhanced Population. Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected. For any other eligible adult member who is not pregnant or postpartum, their children and other individuals in the member's household must be individually eligible to receive MTM
Service Limitations and Restrictions	1. This service is limited up to three (3) prepared meals a day, seven days a week 2. Meal services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services 3. If the member is a high-risk child (0-18 years of age) or a pregnant or postpartum person meeting needs-based criteria, additional meal support may be provided for eligible household members as determined by individual Screening and Eligibility Assessments. If other household members do not meet the Enhanced Population criteria, they should have the FFS Eligibility Assessment for metric purposes. Services for these members should be coordinated with the HRSN service provider and billed to the high-risk child or pregnant or postpartum member. 4. Meals can only be delivered to the enrolled member's home or private residence 5. Members who receive home delivered medically tailored meals cannot also receive Clinically Appropriate Meals, Pantry Stocking (Fresh Produce and Non-Perishable Groceries) or Medically Tailored / Nutritionally Appropriate Food Prescription 6. MTM must adhere to standards informed by established nutrition guidelines, such as the Food is Medicine Coalition (FIMC) MTM Nutrition Standards for specific health conditions, and be tailored to member's health condition 7. Member must undergo intake / assessment that is approved by RDN or CDN 8. Meals must be designed by an RDN or CDN to meet all of the member's medical and nutritional requirements 9. Medical Nutrition Therapy to support a member's behavior change can be billed to the service Nutrition Counseling and Education, as needed
Allowable Providers	1. Contracted Home Delivered Meal service providers that are designated as a non-profit community-based organization 501 (c)(3) or 501(c)(4) 2. Contracted Home Delivered Meal services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) community-based organization. *(See HRSN Network Capacity and Access section for details)*

Medically Tailored Meals: Eligibility and service details	
	3. Providers must have knowledge of principles, methods, and procedures of the Nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety 4. Medically Tailored Meal providers must provide an initial nutritional assessment with approval by an RDN or CDN. RDNs or CDNs must also develop and be involved with ongoing meal design requirements for the member

3.2b Clinically Appropriate Home Delivered Meals

Home delivered clinically appropriate meals will be available to Medicaid Managed Care members who have an identified unmet HRSN for nutrition and meet specific eligibility requirements. Meal plans will be approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN), and designed to improve health outcomes, lower cost of care, and increase member satisfaction.

Clinically appropriate meals must provide well-balanced, nutritionally appropriate meals that adhere to evidence-based nutritional guidelines. Clinically appropriate meals promote health and wellness for enhanced populations who have an unmet HRSN under the food domain and meet the USDA definition of low food security but do not have chronic conditions and are not pregnant/postpartum persons. All meals provided must be approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) and must adhere to standards informed by appropriate nutrition guidelines.

Clinically Appropriate Meals requires RDN / CDN involvement in two steps:

1. **Initial intake / assessment with the member**: The initial member intake / assessment must be approved by an RDN or CDN. Any employee of the HRSN service provider may conduct intake with the member, so long as an RDN or CDN reviews and signs off.
2. **Oversight and meal plan design:** An RDN or CDN must design and approve a member's Clinically Appropriate Meals in order to ensure meals meet all of the member's medical nutrition requirements. RDN / CDN involvement and design of the meal plan is included in reimbursement rate for services.

To streamline member experience, OHIP recommends that HRSN service providers have in-house RDN/CDNs to conduct this oversight and provide approvals. HRSN service providers may have RDN/CDN as direct employee or as a sub-contractor paid directly by HRSN service provider. However, if necessary, HRSN service providers may use an RDN/CDN centralized and staffed at the SCN Lead Entity for member intake and meal approval. If using an RDN/CDN centralized at the SCN Lead Entity, HRSN service providers may NOT include time spent by RDN/CDN when billing for services. SCN Lead Entities may NOT bill for RDN/CDN time as part of services, but may use infrastructure funds to staff an RDN/CDN.

Social Care Navigators should refer members to Nutrition services for the maximum duration and dose of the service. In general, OHIP expects this maximum duration and dose will be appropriate to address the HRSNs of most members. However, an HRSN service provider may determine in consultation with the member that a

more limited duration and/or dose are more appropriate for the member's circumstances. The HRSN service provider should invoice the SCN Lead Entity for the actual quantity of service provided.

Table 5-37: Clinically Appropriate Home Delivered Meals: Eligibility and service details

Clinically Appropriate Home Delivered Meals: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14 2. Cannot prepare their own meals *(see Eligibility Assessment Process for specific questions Social Care Navigator should ask member to make this determination)* 3. Meets the additional clinical criteria in Table 5-15 4. If an eligible member is a high-risk child under the age of 18, additional Medicaid Managed Care-enrolled individuals in the member's household may receive clinically appropriate meals regardless of if those individuals are part of an Enhanced Population. Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected 5. If an eligible member is pregnant or postpartum, additional Medicaid Managed Care-enrolled individuals in the member's household may receive clinically appropriate meals regardless of if those individuals are part of an Enhanced Population. Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected For any other eligible adult member who is not pregnant or postpartum, their children and other individuals in the member's household must be individually eligible to receive clinically appropriate meals
Service Limitations and Restrictions	1. This service is limited to three (3) prepared meals a day, seven days a week 2. Meal services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services 3. If the member is a high-risk child (0-18 years of age) or a pregnant or postpartum person meeting needs-based criteria, additional meal support may be provided for the household as determined by individual Screening and Eligibility Assessments. If other household members do not meet the Enhanced Population criteria, they should have the FFS Eligibility Assessment for metric purposes. Services for these members should be coordinated with the HRSN service provider and billed to the high-risk child or pregnant or postpartum member. 4. Meals can only be delivered to the enrolled member's home or private residence 5. Members who receive clinically appropriate meals cannot also receive Medically Tailored Meals, Pantry Stocking (Fresh Produce and Non-Perishable Groceries) or Medically Tailored / Nutritionally Appropriate Food Prescription 6. Clinically appropriate meals must provide well-balanced, nutritionally appropriate meals that adhere to evidence-based nutritional guidelines. 7. Member must undergo intake / assessment that is approved by RDN or CDN

Clinically Appropriate Home Delivered Meals: Eligibility and service details	
	8. Meals must be designed by an RDN or CDN to meet all of the member's medical nutrition requirements 9. Medical Nutrition Therapy to support a member's behavior change can be billed to the service Nutrition Counseling and Education, as needed
Allowable Providers	1. Contracted Home Delivered Meal service providers that are designated as a non-profit community-based organization 501 (c)(3) or 501(c)(4) 2. Contracted Home Delivered Meal services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) community-based organization. *(See HRSN Network Capacity and Access section for details)* 3. Providers must have knowledge of principles, methods, and procedures of the Nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety 4. Clinically Appropriate Meal providers must provide an initial nutritional assessment with approval by an RDN or CDN. RDNs or CDNs must also develop and be involved with ongoing meal design requirements for the member

3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions

Medicaid Managed Care members who have an identified unmet HRSN for nutrition and meet eligibility criteria may be eligible for Medically Tailored or Nutritionally Appropriate Food Prescriptions (dairy, produce, meat, grains and spices). Qualified members may elect to receive this service either as a nutrition voucher or food boxes. Meal boxes are approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) and designed to improve health outcomes, lower cost of care, and increase member satisfaction.

Medically Tailored or Nutritionally Appropriate Food Prescriptions issued in the form of vouchers or coupons may only be redeemed at food pharmacies, food pantries, grocery stores, farmer's markets, mobile markets, and Community Supported Agriculture (CSA) subscriptions. Members who opt for food boxes will receive a weekly delivery of food appropriate for complete weekly meals.

If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months postpartum.

Social Care Navigators may refer eligible members for either food boxes or nutrition vouchers based on each member's preference.

HRSN service providers may charge for food, delivery, and administrative costs associated with each member's food prescription services. Costs associated with the initial intake / assessment and meal plan design may be billed under the reimbursement range, if RDN / CDN is in-house (employed directly by HRSN service provider or sub-contracted). SCN Lead Entities should monitor HRSN service providers' costs within the reimbursement range to ensure program efficiency.

Food Boxes: Food boxes curated by an RDN or CDN will include enough delivered items per box to create an estimated 3 meals a day, 7 days a week (21 meals) with amount of food meeting the recommendations of the

RDN or CDN. Hunger Prevention and Nutrition Assistance Program (HPNAP) may be used as a resource for HRSN service providers designing this service. Food boxes should follow appropriate nutritional standards.

Nutrition Vouchers: Vouchers developed by an RDN or CDN will have a stated dollar amount to reasonably cover the cost of preparing 21 nutritious meals per week. RDNs or CDNs must develop and be involved with ongoing voucher redemption with the member.

Medically Tailored or Nutritionally Appropriate Food Prescriptions requires RDN / CDN involvement in two steps:

1. **Initial intake / assessment with the member**: The initial member intake / assessment must be approved by an RDN or CDN. Any employee of the HRSN service provider may conduct intake with the member, so long as an RDN or CDN reviews and signs off.
2. **Oversight and meal plan design:** An RDN or CDN must design and approve a member's Food Prescription boxes or vouchers in order to ensure meals meet all of the member's medical nutrition requirements. RDN / CDN involvement and design of the food prescription is included in reimbursement rate for services.

To streamline member experience, OHIP recommends that HRSN service providers have in-house RDN/CDNs to conduct this oversight and provide approvals. HRSN service providers may have RDN/CDN as direct employee or as a sub-contractor paid directly by HRSN service provider. However, if necessary, HRSN service providers may use an RDN/CDN centralized and staffed at the SCN Lead Entity for member intake and meal approval. If using an RDN/CDN centralized at the SCN Lead Entity, HRSN service providers may NOT include time spent by RDN/CDN when billing for services. SCN Lead Entities may NOT bill for RDN/CDN time as part of services but may use infrastructure funds to staff an RDN/CDN.

Social Care Navigators should refer members to Nutrition services for the maximum duration and dose of the service. In general, OHIP expects this maximum duration and dose will be appropriate to address the HRSNs of most members. However, an HRSN service provider may determine in consultation with the member that a more limited duration and/or dose are more appropriate for the member's circumstances. The HRSN service provider should invoice the SCN Lead Entity for the actual quantity of service provided.

Table 5-38: Medically Tailored or Nutritionally Appropriate Food Prescriptions: Eligibility and service details

Medically Tailored or Nutritionally Appropriate Food Prescriptions: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14 and 2. Meets the clinical criteria in Table 5-15 3. If an eligible member is a high-risk child under the age of 18, additional Medicaid Managed Care-enrolled individuals in the member's household may receive Food Prescriptions regardless of if those individuals are part of an Enhanced Population. Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected 4. If an eligible member is pregnant or postpartum, additional Medicaid Managed Care-enrolled individuals in the member's household may receive food prescriptions regardless of if those individuals are part of an Enhanced Population. Additional

Medically Tailored or Nutritionally Appropriate Food Prescriptions: Eligibility and service details	
	individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected For any other eligible adult member who is not pregnant or postpartum, their children and other individuals in the member's household must be individually eligible to receive food prescriptions
Service Limitations and Restrictions	1. This service is limited to weekly delivery of food appropriate for complete weekly meals 2. This service is limited to food or vouchers to cover three (3) meals a day 3. Meal services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services If the member is a high-risk child (0-18 years of age) or a pregnant or post-partum person meeting needs-based criteria, additional meal support may be provided for eligible household members as determined by individual Screening and Eligibility Assessments. If other household members do not meet the Enhanced Population criteria, they should have the FFS Eligibility Assessment for metric purposes. Services for these members should be coordinated with the HRSN service provider and billed to the high-risk child or pregnant or postpartum member. 4. Meals can only be delivered to the enrolled member's home or private residence 5. Members who receive Medically Tailored or Nutritionally Appropriate Food Prescription services cannot also receive Pantry Stocking (Fresh Produce and Non-Perishable Groceries) or Medically Tailored or Clinically Appropriate Home Delivered Meals 6. Member must undergo intake / assessment that is approved by RDN or CDN 7. Food boxes or vouchers must be curated by an RDN or CDN to meet all of the member's medical nutrition requirements 8. Medical Nutrition Therapy to support a member's behavior change that can be billed to the service Nutrition Counseling and Education, as needed
Allowable Providers	1. Contracted Medically Tailored or Nutritionally Appropriate Food Prescription providers that are designated as a non-profit community-based organization 501(c)(3) 2. Contracted Medically Tailored or Nutritionally Appropriate Food Prescription providers may be offered by for-profits organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) CBO. *(See HRSN Network Capacity and Access section for details*) 3. Providers must have knowledge of principles, methods, and procedures of the Nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

Medically Tailored or Nutritionally Appropriate Food Prescriptions: Eligibility and service details	
	4. Food Prescription providers must provide an initial nutritional assessment with approval by an RDN or CDN. RDNs or CDNs must also curate Food Prescription boxes and vouchers

3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)

Medicaid Managed Care members who have an identified unmet HRSN for nutrition, meet specific population eligibility criteria, and are deemed eligible during the Eligibility Assessment with SCN may be eligible for pantry stocking of fresh produce and nonperishable groceries. Pantry Stocking cannot include perishable dairy or meat items. Provision of this service is limited to high-risk children under age 18 and pregnant/postpartum persons, for up to six months. Pregnant individuals, as defined in Table 5-13, may receive up to 21 months of fresh produce and non-perishable groceries (Pantry Stocking).

Fresh Produce and Non-Perishable Groceries will serve to nutritionally supplement as estimated 3 meals a day, 7 days a week (21 meals per week). Hunger Prevention and Nutrition Assistance Program (HPNAP) may be used as a resource for HRSN service providers designing this service. Pantry Stocking will be delivered/picked up to the member in a weekly box. Pantry Stocking will not include meat or dairy products. OHIP recommends that food items provided in Pantry Stocking are nutritionally appropriate (e.g., fresh, frozen, canned fruits and vegetables; canned meats; shelf-stable milk products; plant-based proteins; dried goods; grains; seasonings; spices).

HRSN service providers may charge for food, delivery, and administrative costs associated with each member's Pantry Stocking services. SCN Lead Entities should monitor HRSN service providers' costs within the reimbursement range to ensure program efficiency.

Social Care Navigators should refer members to Nutrition services for the maximum duration and dose of the service. In general, OHIP expects this maximum duration and dose will be appropriate to address the HRSNs of most members. However, an HRSN service provider may determine in consultation with the member that a more limited duration and/or dose are more appropriate for the member's circumstances. The HRSN service provider should invoice the SCN Lead Entity for the actual quantity of service provided.

Table 5-39: Fresh Produce and Non-Perishable Groceries (Pantry Stocking): Eligibility and service details

Fresh Produce and Non-Perishable Groceries (Pantry Stocking): Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14 and 2. Meets the clinical criteria in Table 5-15 3. If an eligible member is a high-risk child under the age of 18, additional Medicaid Managed Care-enrolled individuals in the member's household may receive Pantry Stocking regardless of if those individuals are part of an Enhanced Population. Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected 4. If an eligible member is pregnant or postpartum, additional Medicaid Managed Care-enrolled individuals in the member's household may receive Pantry Stocking regardless of if those individuals are part of an Enhanced Population.

Fresh Produce and Non-Perishable Groceries (Pantry Stocking): Eligibility and service details	
	Additional individuals in the household must first receive a Screening and have an unmet Nutrition HRSN detected For any other eligible adult member who is not pregnant or postpartum, their children and other individuals in the member's household must be individually eligible to receive Pantry Stocking
Service Limitations and Restrictions	1. Pantry Stocking service is limited to high-risk children under age 18 and pregnant/postpartum individuals who qualify under criteria in Table 5-13 2. Meal services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services 3. If the member is a high-risk child (0-18 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for eligible household members as determined by individual Screening and Eligibility Assessments. If other household members do not meet the Enhanced Population criteria, they should have the FFS Eligibility Assessment for metric purposes. Services for these members should be coordinated with the HRSN service provider and billed to the high-risk child or pregnant or postpartum member. 4. Members who receive Fresh Produce or Non-Perishable Groceries (Pantry Stocking) cannot also receive Medically Tailored or Nutritionally Appropriate Food Prescription or Medically Tailored or Clinically Appropriate Home Delivered Meals
Allowable Providers	1. Contracted Pantry Stocking service providers that are designated as a non-profit community-based organization 501(c)(3) 2. Contracted Pantry Stocking services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) CBO. (*See HRSN Network Capacity and Access section for details).* 3. Providers must have knowledge of principles, methods, and procedures of the Nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

3.5 Cooking Supplies

Medicaid Managed Care inclusive of MLTCP and MAP members who have an identified unmet HRSN for nutrition may qualify for cooking supplies that are necessary for meal preparation and nutritional welfare when not available through other programs. Service is available up to a capped per member amount, as determined by each SCN Lead Entity, and can include, but is not limited to:

- Kitchenware (e.g., plates, bowls, cooking utensils, mixing bowls, pots and pans, chef's knife, cutting board, eating utensils, silverware, glassware, can opener, colander)
    - Small appliances to support meal preparation and nutritional welfare (e.g., blender)
- Microwave
- Full size refrigerator
    - Social Care Navigators are strongly encouraged to spend no more than $600 per refrigerator. The refrigerator listed in this section is independent from the medical mini refrigerator available under Service 2.2c Home Remediation

When appropriate, Social Care Navigators may coordinate the purchase of a member's cooking supplies if more efficient than referring to an HRSN service provider. A Social Care Navigator should refer the member to service 3.5 Cooking Supplies and accept the referral as the HRSN service provider to deliver the service. After accepting the referral, the Social Care Navigator may complete the purchase**.** Time spent by Social Care Navigators on coordination of services (ordering supplies) may be billed to Enhanced Care Management.

For HRSN service providers that are not Social Care Navigators, time spent coordinating the purchase of a member's cooking supplies may be billed under the Cooking Supplies service. Reimbursement for Cooking Supplies is based on actual costs, subject to a per member cap set by SCNs, based on the total SCN-level cap listed in the HRSN Fee Schedule. HRSN service providers' coordination costs are capped at 5% of the cost of each member's cooking supplies.

Table 5-40: Cooking Supplies: Eligibility and service details

Cooking Supplies: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14 and 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Medicaid Managed Care members may not qualify for this service if provision for cooking supplies is being offered by another program or if the member received Community Transitional Supports authorized under this 1115 Waiver 2. Service is available up to a capped per member amount, as set by SCNs, based on the SCN-level cap listed in the HRSN Fee Schedule 3. If the HRSN service provider is a tax-exempt entity (e.g., 501(c)3), the HRSN service provider must ensure their purchases are tax-exempt
Allowable Providers	1. Contracted Cooking Supply service providers that are designated as a non-profit community based organization 501(c)(3) 2. Contracted Cooking Supply service providers may be offered by for-profits organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) community-based organization. (*See HRSN Network Capacity and Access section for details).* 3. Nutrition services providers must have knowledge of principles, methods, and procedures of the Nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and

Cooking Supplies: Eligibility and service details	
	meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

4. Transportation

4.1 Transportation Services

Transportation services may be available to eligible Medicaid Managed Care members who have an identified unmet HRSN and meet the criteria required for Enhanced HRSN Service within Table 5-15.

Table 5-41: Transportation Screening questions

Transportation Screening questions	
1. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	• Yes • No

Qualified members may receive access to public or private transportation services (e.g., taxi/livery, rideshare/Transportation Network Company (TNC), public transportation) to utilize Enhanced HRSN Services and/or care management activities for which they have been referred. The member's need for Transportation services must be documented in their Social Care Plan. Payment for Transportation Services should not be paid directly to a member. The SCN should provide payment to the Transportation provider directly.

Examples of Enhanced HRSN Services include HRSN-related activities such as:

- Housing appointments;
- Housing court (eviction prevention);
- Local Department of Social Services / Vital Records appointments;
- Local Department of Motor Vehicles appointments;
- Education and support for chronic conditions;
- Court, probation, parole, and order of protection-related appointments;
- Childcare / Parenting classes; and
- Transportation to food pharmacies, farmer's markets, mobile markets, etc.

The Social Care Navigator, who is directly involved in addressing the member's HRSN needs, will determine the most cost-effective and appropriate mode of transportation to meet the unique needs of each member. If a Medicaid member uses the public transit system for the activities of daily life, then, in most circumstances, transportation for the member should be requested at a mode of transportation no higher than that of the public transit system. Service is available for a maximum duration of 6 months, with possibility of re-authorization, up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services. As a guiding principle, services are not intended to be permanent solutions, and Social Care Navigators should work to connect members to more permanent resources (existing federal, state, and local services) where possible.

Transportation planning is the responsibility of, and can be billed for by, the member's Social Care Navigator under Enhanced Care Management or may be conducted by the HRSN service provider and billed under the Transportation service. Outside of Social Care Navigation, the cost of transport and transportation coordination (e.g., coordination with rideshare services) can be billed for by the HRSN service provider under the respective Transportation Services code. OHIP will track spend against the SCN cap for this service, in addition to collecting encounter data via social care claims. Transportation providers using volunteer drivers should not bill SCN Lead Entities for volunteers' time spent transporting members but may bill for other costs associated with providing HRSN Transportation Services (e.g., gas).

See section d. v. Considerations for children, youth and households under "Additional considerations for Transportation services" for coverage details on situations when a child or adult rides with a household member not eligible for Transportation services.

Table 5-42: Transportation: Eligibility and service details

Transportation: Eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-13 and Social Risk Factors in Table 5-14 and 2. Meets the clinical criteria in Table 5-15
Service Limitations and Restrictions	1. Transportation Services are not the same as Medicaid Transportation and are not tied to it in any way 2. Transportation Services may only be used for activities related to accessing Enhanced HRSN Services and/or care management services 3. Transportation Services are only reimbursable for actual services rendered to the member. If a member fails to show for a scheduled appointment then it cannot be reimbursed. 4. Transportation is a limited service and should only be used when there are no other transportation options for the member 5. Transportation Services may be provided to a qualified member's caregiver or guardian for the direct benefit of the member 6. Service is available for a maximum duration of 6 months, with possibility of re-authorization, up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services. As a guiding principle, services are not intended to be permanent solutions, and Social Care Navigators should work to connect members to more permanent resources (existing federal, state, and local services) where possible.
Allowable Providers	1. Contracted Transportation service providers that are designated as a non-profit community-based organization 501(c)(3). 2. Contracted Transportation Services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) community-based organization. (*See HRSN Network Capacity and Access section for details).* 3. All Contracted Transportation service providers must have a valid: New York or other valid state driver license, vehicle registration, vehicle inspection, Certificate of Insurance, and insurance identification cards.

	4. Transportation service providers can use volunteer drivers that meet the driver qualifications above 5. Family members of a member receiving Transportation Services cannot provide transportation to the member as a volunteer driver for a Transportation service provider

Congestion Pricing

Congestion pricing is in effect in Manhattan, with congestion tolls charged to vehicles driving below 96th street and additional congestion tolls charged to vehicles driving below 60th street. **NYHER funds cannot be used to pay congestion tolls under any circumstances.** SCN Lead entities and contracted transportation providers should follow the guidance below, which was in effect as of 1/05/2025.

Members eligible for Enhanced Transportation Services should be connected with public transportation wherever possible, and OHIP expects most rides through Manhattan to involve public transportation (e.g., MTA subway or bus, MTA Access-A-Ride). In certain circumstances, a member eligible for Enhanced Transportation Services may require a private ride (e.g., taxi or rideshare). OHIP encourages Social Care Navigators to refer members to services in their communities. However, in some cases, it may be necessary for a member to ride through the Manhattan Congestion Relief Zone (CRZ) to access a service.

Recommend enrollment in the Per-Trip Charge Plan

All Transportation providers operating in the NYC area and contracted into SCNs are encouraged – but not required – to enroll in the Per-Trip Charge Plan (PTCP), a program that affords discounted congestion pricing for for-hire vehicles (FHVs) entering the CRZ. Vehicles registered to organizations enrolled in PTCP will be charged $0.75 per trip (green/yellow taxis and black cars) or $1.50 per trip (high-volume FHVs) through the CRZ below 60th street, instead of the usual $9 per day congestion toll.

FHV rides that begin in, end in, or pass through the CRZ will be subject to an additional congestion surcharge of $2.50, if Transportation providers are not enrolled in PTCP. If transportation providers are enrolled in PTCP, there are no additional fees to rides that originate and end inside the CRZ.

To enroll in PTCP, Transportation providers must first join a Taxi & Limousine Commission (TLC) base.

Enrolling in PTCP is done through the Transportation service provider's TLC base, which functions as both an operating and dispatching base for FHVs. TLC bases seeking to enroll their vehicles in PTCP will need to execute and deliver the PTCP agreement to the Metropolitan Transportation Authority (MTA). The PTCP agreement includes the following:

- The organization must enter into the Central Business District (CBD) Tolling Program FHV Base Per-Trip Charge FHVB Plan Acceptance Agreement with the Triborough Bridge and Tunnel Authority (TBTA)
- Within three business days from the effective date of the agreement, the organization must provide a Vehicle Data Report, including vehicle license plate numbers, state that issued the license plates, and vehicle types
- The organization must ensure the accurate collection of the CBD FHV Toll Charge for each CBD Trip and retain records. Payments must be made monthly within thirty calendar days after the end of each month in which a CBD Trip occurred
- The organization must implement geofencing or other effective technology to ensure the correct application and collection of the CBD FHV Toll Charge for each trip

- The organization must maintain records of each CBD Trip and related payments for no less than six years after the date of payment

More information on PTCP and how to enroll can be found on the MTA website *(see section titled "FHV enrollment").* Transportation providers contracted with the SCN Lead Entity who meet the criteria to join a TLC base and PTCP requirements should make every effort to enroll.

Guidance on congestion toll invoicing and reimbursement

Transportation providers who deliver a ride through the CRZ – regardless of their enrollment in PTCP – should submit a separate invoice to the SCN Lead Entity for the congestion toll paid, distinct from the cost-based invoice for the rest of the ride. Transportation providers will receive a separate payment for the congestion pricing portion of the ride than for the rest of the cost of the ride. SCN LEs are required to maintain detailed documentation on congestion toll invoices submitted from Transportation service providers.

For all members receiving Transportation services that involve congestion tolls, SCN Lead Entities will submit claims via eMedNY.

See below for guidance related to invoices and reimbursement for each component of the ride.

Table 5-43: Guidance for invoicing with congestion tolls

Component of ride / invoice	Information included on invoice	Reimbursement process	Implications for payment timing and reporting
Cost of ride *excluding* congestion pricing toll	Transportation Services providers generate an invoice for the cost of the ride excluding the congestion pricing toll Invoices for the main ride should include all fields as outlined in the SCN Data & Systems Implementation Guide (DSIG)	SCN Lead Entity reimburses Transportation provider for the cost of the ride through standard process via NYHER	Provider is reimbursed per standard payment terms Cost of services provided are included in standard NYHER reporting
Congestion pricing toll	Transportation Services providers generate a separate invoice for ONLY the cost of the congestion pricing toll Invoices for congestion tolls should include all fields as outlined in the DSIG as well as:	**SCN LEs may NOT use NYHER funds to reimburse Transportation service providers for the cost of congestion tolls.** SCN LEs should wait until they receive reimbursement from OHIP via the process below to pay the Transportation provider for the cost of the congestion toll.	SCN LEs will be reimbursed upon receipt of a submitted claim, as specified in the SCN Provider Policy Manual SCN LEs should only reimburse Transportation providers for congestion tolls AFTER they have

Component of ride / invoice	Information included on invoice	Reimbursement process	Implications for payment timing and reporting
	(A) Pick-up and drop off address or GPS data to show the trip entered the CRZ **(B)** Proof that congestion toll was paid (e.g., EZ Pass receipt) **(C)** Attestation from Transportation provider that trip was part of Enhanced HRSN services delivered to an eligible member	SCN LEs should follow the steps below to receive reimbursement for the congestion toll: **(1)** Submit a FFS claim through eMedNY using the process outlined in Section 7)c)ii (Payment Methodology for Services Delivered – Uses of Funding) and in the SCN Provider Policy Manual • Include Procedure Code: A0110; with Modifier TJ in the claim to flag as congestion pricing toll **(2)** Receive reimbursement through eMedNY **(3)** Reimburse Transportation service providers for congestion toll	received reimbursement from OHIP via eMedNY Congestion pricing tolls will be excluded from NYHER reporting

k. PARTNERSHIPS

i. State and local partnerships

Per STC 6.17 (Partnerships with State and Local Entities) and STC 6.19 (c)(ii) request, partnerships with state and local entities are essential to the success of the SCN. To achieve this, each regional SCN Lead Entity will be expected to create a detailed directory of all federal, state, and local agencies that can serve the unique needs of their region.

OHIP expects SCN Lead Entities to demonstrate an understanding of the different stakeholders and potential partners in the region and detail any existing relationships they have that may be leveraged to address the needs of populations eligible for Enhanced HRSN Services. These partnerships will also foster a greater understanding of the broader social care supports (e.g., SNAP, WIC, TANF, federal, state and local housing authorities etc.) that members may need. SCN Lead Entities will be expected to provide reports on the number of members referred specifically to WIC (DOH), or connected to SNAP and TANF (OTDA), federal, state, and local housing authorities by use of SNOMED coding and tracking of these services under Care Management.

OHIP plans for SCNs to work in coordination with entities in the region to address the social care needs of populations eligible for Enhanced HRSN Services, such as pregnant / postpartum persons, Medicaid High Utilizers, those with SUD, SMI, SED or I/DD, foster youth, and criminal justice-involved individuals. OHIP will require SCN Lead Entities to leverage existing partnerships or develop new relationships with MCOs, ecosystem partners, 29-I agencies, local governments, jails, prisons, local housing authorities, HUD Continuum of Care (CoC) partners, school districts and other stakeholders, to adequately address the social care needs of populations eligible for Enhanced HRSN Services in the region. These partnerships may involve collaboration on individual member cases, on population health initiatives, or value-based payment (VBP) initiatives.

In particular, the following HRSN Service Providers are encouraged to contract~~must contract~~ with the SCN Lead Entities:

1. PCMH. As of April 1, 2025, some primary care providers recognized under the NYS Patient Centered Medical Home (PCMH) ~~program are required~~ have attested to their commitment to work with SCNs in order to recei~~ieve~~t~~o~~ continued ~~to receive the~~ incentive enhancements paid by NYS DOH (see section 8.f. for more details and requirements).

2. Medicaid Redesign Team (MRT) Supportive Housing ~~Program~~ Initiatives and Empire State Supportive Housing Initiative (ESSHI)

The primary referral source for the MRT Supportive Housing Program is from the SCN LEs. It is expected that all MRT housing providers or their subcontractors ~~will~~ have a contract with the SCN LEs in order for the SCN to send referrals for eligible ~~participants~~ members. MRT Supportive Housing Program subcontractors are inclusive of the following: ~~Empire State Supportive Housing Initiative (ESSHI)~~Health Home Supportive Housing Program (HHSHP) and NYAIL subcontractors Rapid Transitional Housing (RTH) and Olmstead Housing Subsidy (OHS). SCN LEs should send referrals directly to the subcontractors for NYAIL: RHT and OHS.

OHIP expects SCN LEs to initiate contracting efforts with all MRT Supportive Housing Program subcontractors and separately with ESSHI providers in their region. Contracting means~~responsibilities may include~~:

- ESSHI and MRT Housing Providers (or their subcontractors) can receive reimbursement for Screening and Eligibility Assessments for both enrolled participants and non-enrolled participants.
- When applicable, EESHI and MRT housing providers can be contracted to provide Enhanced HRSN services to **non-enrolled residents** for services such as Housing Transition and Navigation Services, and Tenancy Sustaining Services. In the event that the EESHI Housing Provider or MRT Housing Provider (or their subcontractors) ~~contract does~~does not have enough funding for Community Transitional Supports (Tenant Contingency for EESHI), then the SCN can provide reimbursement for ~~CTS of~~ eligible members per 2.8 Community Transitional Supports (CTS) ~~individuals~~.

~~SMRT Housing Providers can also be paid for Screening and Eligibility Assessments for both SMRT participants and non-participants.~~ OHIP has shared a list of all EESHI providers and MRT providers along with their contact information on the SCN LE SharePoint. Additional information on the ESSHI and MRT Supportive Housing Programs can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/supportive_housing_initiatives.htm

Existing Local, State and Federal Partners

Social Care Navigators will navigate and refer Medicaid FFS, ineligible Medicaid Managed Care members or eligible Medicaid members who wish to opt in to existing local, state, and federal services when the member has at least one identified unmet HRSN in their Screening. Existing services will not receive any 1115 Waiver funding for providing their services. The Social Care Navigator will also bridge the gap for eligible Medicaid Managed Care member's facing the ending of their HRSN service duration to ensure continuation of care. Specifically, SCNs will be required to coordinate any Enhanced HRSN Service to transition the member to existing federal, state, and local services 60 days prior to end of Enhanced HRSN Services.

SCNs will consider existing programs and individually report on the number of members referred to each. The SCN IT Platform's Closed Loop Referral system will allow the SCN Lead Entity to monitor and report to OHIP the connection to existing services and ensure the member has successful accessed the existing programs for services. ~~L1 service requests for Eligibility Assessment should include all permitted service fulfillment statuses and L1 service requests for all other 1.1 Navigation services should only include the "completed" service fulfillment status.~~After a member agrees to navigation, Social Care Navigators must change the status to "Completed"

The below are specific existing programs the SCN Lead Entity will need to report the number of members referred / connected to by use of SNOMED coding and tracking. This list is not exhaustive of existing programs but will include vital partnerships such as:

Entity	**SNOMED Description**	**SNOMED Code**
SNAP (OTDA)	Referral to Supplemental Nutrition Assistance Program (procedure) - SNAP	464101000124108
WIC (DOH)	Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure) - WIC	464111000124106
TANF (OTDA)	Referral to Temporary Assistance for Needy Families program (procedure) - TANF	621331000124108
HEAP (OTDA)	Referral to Low Income Home Energy Assistance program (procedure)	621361000124104
Local, State and federal housing	Referral to housing support program (procedure)	472161000124106

ii. Health Equity Regional Organization (HERO)

United Hospital Fund (UHF) is the contracted HERO for New York State under the 1115 waiver and will be charged with bringing stakeholders together to collaboratively support and augment public health, social services, health-related social need services, data governance, data management, regional needs, assessment and planning, VBP design and development, program evaluation and health care delivery for New York State's Medicaid members.

The SCN Lead Entities will each remain an independent entity that will participate with the HERO but are not overseen by the HERO. Additional information about UHF can be found on the following website: UHF to Lead Coordination of New York State Health Equity Regional Organization (HERO) | United Hospital Fund.

iii. Proactive member Screening outreach strategies

To meet Screening targets, SCN Lead Entities are expected to develop approaches to conduct proactive outreach to members for Screening to maximize the number of individuals screened, particularly through partnerships and collaboration with other organizations. These approaches should include but are not limited to:

- **Collaboration with Organizations:** Working with organizations in the Network to offer Medicaid members the opportunity to be screened
- **Communication Channels with MCOs:** Maintaining communication channel(s) with MCOs in the SCN's region to direct member(s) to the SCN if the MCO identifies a member in need of Screening
- **Communication Channels with Providers:** Maintaining communication channel(s) with health care or care management providers in the SCN's region to direct a member to the SCN if the provider identifies a member in need of Screening, especially those who treat a large number of Medicaid members
- **Community Outreach Strategy:** Developing an outreach strategy in collaboration with organizations in the Network to reach members in neighborhoods identified as having health disparities to encourage HRSN Screening

Examples of SCN strategies for targeted outreach could include:

- Leverage "seek and screen" lists (e.g., based on ESMF per clinical criteria). SCN LEs are encouraged to coordinate with their SCN IT Platform vendor to obtain an aggregate ESMF file across MCOs. The aggregate ESMF list can then be filtered (e.g., asthma) and shared with contracted partners for targeted outreach attempts.
- Send tailored messages via text, email, and mailers
- Partner with organizations / entities who serve enhanced populations (e.g., work with behavioral health IPAs to reach members with SUD/SMI) and/or are in close proximity to enhanced populations (e.g., nearest social care network partners and medical and behavioral health providers).
- Coordinate with MCOs' care management programs serving enhanced populations
- Meet enhanced populations where they are (e.g., community events, back to school events)
- Consider paid advertisements via digital channels which can support audience targeting (e.g., YouTube, Facebook)

I. MEMBER CONSENT

Consent to access and disclose data will be governed by SHIN-NY policies, which are intended to support access to information beyond clinical settings, including the exchange of claims and social care data.

SCNs will collect and receive HRSN Data and other health data about Medicaid members at different stages in the Screening, Eligibility Assessment, and Navigation process. SCNs will need to obtain consent from members and keep members informed about their use of such information. OHIP envisions a consent process that focuses on a meaningful and simple informed consent at each step for the member. In some cases, consent will be documented and shared with the SHIN-NY, and in others, consent may be documented in the SCN's IT System.

Consent processes across Screening, Eligibility Assessment, and Navigation / Referral are detailed below.

i. Member Consent for Screening

Any organization administering an HRSN Screen as part of the NYHER 1115 Waiver must capture member consent as part of each Screening. The SCN must share the member's consent to Screening with the SHIN-NY, which will be documented as an answer in the Screening document itself.

Because OHIP will use Screenings for analytics and others will use Screenings to subsequently identify and reach out to members who may benefit from HRSN services, it is important that members understand the potential uses of their data. The consent explanation of the Screening should be easy to understand and not be a barrier to services. It is important that members understand that their HRSN Data will be shared with the SHIN-NY and will be available to their providers and Health Plan if they have consented to share their data in the regular SHIN-NY manner.

Any member should be allowed to decline the Screening process in whatever setting it is administered. If a member declines, the Screening does not take place.

Required use of Question 0: SCNs and any organization conducting Screenings on their behalf must use New York State's consent notice as "Question 0", preceding other standardized AHC Screening questions. This notice will clearly explain the purpose of the Screening. Member consent may be collected verbally and must be documented in the SCN IT Platform. SCNs and any entities Screening using their native EHRs must use the language below for Question 0:

REVISED CONSENT TO SCREEN (QUESTION 0)

We use this survey to understand needs our [members / patients / clients] have which could interfere with good health. We may share your answers with your other health care providers, and with your health plan and social services organizations, so they can determine if you qualify for any free non-medical services that could be helpful. Please check this box if you agree to continue. You can choose not to answer this survey, but we can only check for services if you do answer.

The lengthier the explanation in Question 0, the less likely it will be fully read and comprehended. However, these additional sentences could also be considered depending on context:

ALTERNATIVE INCLUSIONS IN (QUESTION 0)

- *You can choose to be screened later and may be eligible for extra services at that time.*
- *None of this will affect your ongoing Medicaid eligibility.*

If a member is screened for unmet HRSNs using a platform other than the SCN IT Platform, members will still need to provide consent for the sharing of Screening data (Screening Question 0) as part of the Screening in order for the SHIN-NY to share the Screening data with the SCN Lead Entity to proceed with the Eligibility Assessment. Please refer to section e.

ii. Member Consent for Eligibility Assessment

Following a Screening that identifies an unmet HRSN, SCNs will conduct an Eligibility Assessment. SCNs must obtain member consent before proceeding with an assessment. ~~The elements of the message and the method of capturing consent are still being finalized – details will be shared at a later date. Access to social services data may require specific language, which is not yet finalized.~~ For purposes of accessing other health records, the consent will need to minimally include a brief explanation that a member's health data will be used in the process. Simple member education should be provided and may be included as part of a broader consent process. For health data use purposes, approval by the member to proceed may be provided verbally and documented.

At a minimum, verbal affirmation from a member is required to proceed with use of their health data. A member should have the choice to say no and to stop the process from moving forward. The fact that a member was given this opportunity must be recorded in the SCN's IT Platform.

MEMBER "APPROVAL" TO PROCEED WITH ASSESSMENT

I would like to see, based on your medical history including information Medicaid collects and from Social Services organizations, if you qualify for any services that could be helpful and which would be free to you. Is this okay with you? Do you have any questions?

iii. Member Consent for Referral / Navigation

Before a SCN refers a member for an Enhanced HRSN Service, the SCN must inform the member that their information will be shared with an HRSN service provider. The referral process should be described in a simple manner, and the member's affirmative verbal consent should be recorded in the SCN IT Platform. This consent enables SCNs to safely transmit PHI to the HRSN service provider if the data meets the minimum necessary criteria and is what a reasonable person would expect to be included.

Ideally, the SCN obtains consent to refer immediately following the assessment process while the member is in person or on the phone. Otherwise, a follow-up to receive consent for referral could result in a delay in the referral and subsequent service provision. Most importantly, the SCN's workflow should prioritize ensuring the members' clear understanding of each step of the process. For a member, there should be no surprises in how their information is used and to whom it is sent.

DRAFT CONSENT TO REFER

It appears that you qualify for [a service]. This service would be free to you. I'd like to refer you to an organization that provides [this service]. I will need to send them some of your information. Is this okay with you? Do you have any questions?

m. DUPLICATIVE SERVICES

OHIP expects that services delivered by SCNs will supplement, not supplant, services that are already received by members, including but not limited to existing state and federal programs and In Lieu of Services (ILOS) provided by MCOs. Before authorizing Enhanced HRSN Services, the SCN Social Care Navigator must ensure the

member is not receiving duplicative services through other programs. For example, if a member is already receiving Mold and Pest Remediation services through another state program such as Healthy Homes, they should not receive Mold and Pest Remediation services from the SCN. This section outlines potentially duplicative services between SCN and other programs (Table 5-43) and key components of the workflow that a Social Care Navigator should follow in ensuring services are not duplicative for a given member (Table 5-45). See Table 5-15 as well for a view of how to consider duplicative services alongside other eligibility criteria for Enhanced HRSN Services.

Table 5-44: Services offered through existing programs and waivers that may be duplicative of Enhanced HRSN Services

Service Category	Program / Service	Healthy Homes	Nutritional Counseling	MTM ILOS	OPWDD Waiver	TBI Waiver	NHTD Waiver	Children's Waiver	Medicaid Advantage Program	MLTCP
Housing	2.1 Medically necessary Home and Safety Modifications				*Home Modifications*	*Home Modifications*	*Home Modifications*	*Home Modifications*	*Home and Safety Modifications*	*Home and Safety Modifications*
	2.2 Home Remediation								*Home Remediation*	*Home Remediation*
	2.3 Asthma Remediation	*Asthma Remediation*							*Asthma remediation*	*Asthma remediation*
	2.8 Community Transitional Supports				*Moving costs, security deposit*	*CTS (Moving costs, security deposit)*	*CTS (Moving costs, security deposit)*		*CTS*	*CTS*
	2.10 Housing Transition and Navigation Services								*Housing Transition and Navigation Services*	*Housing Transition and Navigation Services*
Nutrition	3.1 Nutrition Counseling and Education		*Nutritional Counseling*				*Nutritional Counseling*			
	3.2 Medically Tailored or Clinically Appropriate Meals			*Medically Tailored Meals*			*Up to 2 meals/day*			

Transportation	4.1 Transportation related to HRSN service		*Transport based on care plan*	*Transport based on care plan*	*Transport based on care plan*	*Transport based on care plan*

A Social Care Navigator's workflow to ensure services are not duplicated should include the following overarching steps:

Step 1: Social Care Navigator conducts Screening and Eligibility Assessment to determine member's HRSNs and the HRSN services for which they are eligible

Step 2: Social Care Navigator checks relevant field in ESMF to determine whether member is receiving HRSN services through another program or waiver. Relevant ESMF fields and guidance for service duplication are summarized in Table 5-44 "Relevant ESMF fields for potential service duplication"

Table 5-45: Relevant ESMF fields for potential service duplication

Field Name	Field Name Description	Format	Guidance
Healthy_Homes	Healthy Homes	Y, N, U	Members are receiving Asthma Remediation services through the Healthy Homes VBP pilot or have received them in the past 12 months
Nutrition_Counsel	Nutritional Counseling	Y, N, U	Members who have received nutritional counseling services in the past 12 months identified using the Medicaid Managed Care Operating Report (MMCOR) encounter categorization under Home Health Care: Nutritional Counseling
MTM_ILOS	Medically Tailored Meals In-lieu of Services (ILOS)	Y, N, U	Members who have received MTM ILOS in the past 90 days, identified using the MMCOR encounter categorization
OPWDD_Waiver	Office for Persons with Developmental Disabilities (OPWDD) Waiver	Y, N, U	Members who have both RRE codes 95 and 46 on the 834 file
TBI_Waiver	Traumatic Brain Injury (TBI) Waiver	Y, N, U	Members who have RRE code = 81 on the 834 file
NHTD_Waiver	Nursing Home Transition Diversion (NHTD) Waiver	Y, N, U	Members who have RRE code = 60 on the 834 file
Childrens_Waiver	Children's Waiver	Y, N, U	Members who have RRE code = K1 on the 834 file

Step 3: Social Care Navigator confirms with member whether they are receiving services as part of the relevant waiver / program

Step 4: Social Care Navigator checks MEVS if required for specific waivers / programs (i.e., if ESMF field name appears as "U" or unknown)

Step 5: Social Care Navigator reaches out to designated point of contact at the other program or waiver only if:

- ESMF field name appears as "Y", OR
- ESMF field name appears as "U" AND member verbally confirms enrollment in program

If needed, reaching out to other program/waiver to check for duplicative services can be conducted at the end of Eligibility Assessment process and time can be billed to 1.2 Enhanced HRSN Care Management.

Social Care Navigator must complete the relevant duplication check(s) before referring member to the specific Enhanced HRSN Service requiring a duplication check. However, the Navigator may refer members to other Enhanced HRSN Service(s) for which they are eligible in the meantime.

Step 6: Social Care Navigator refers the member to Enhanced HRSN service if it is determined that they are not receiving duplicative services through other programs or waivers

Table 5-45 details guidance for how Social Care Navigators should determine whether members are receiving potentially duplicative services through other waivers / programs and implications for referrals to Enhanced HRSN Services.

Table 5-46: Waiver- and program-specific Social Care Navigator workflows

Waiver / program: OPWDD **OPWDD waiver eligibility criteria:** • The individual must have a diagnosis of a qualifying developmental disability • The individual must require a level of care equivalent to that provided in an Intermediate Care Facility **HRSN category: Transportation**		
Relevant services offered via OPWDD Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Services which enable individuals to access authorized HCBS and destinations related to goals included in their care plan (i.e., Residential	Member may receive 4.1 Transportation for trips / destinations that are not covered by OPWDD Waiver Only in rare instances are duplicative	If member has unmet need in transportation domain, is eligible for 4.1 Transportation related to HRSN services, AND… If ESMF says "Y" for OPWDD and member confirms they are receiving services: ● Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by OPWDD waiver If ESMF says "Y" for OPWDD but member indicates they are not receiving services:

Habilitation, Day Habilitation, Site-Based Prevocational Services)	transportation services anticipated between SCN and OPWDD, given narrow scope of OPWDD transportation destinations	• Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by OPWDD waiver If ESMF says "N" for OPWDD and member confirms they are not receiving services: • Social Care Navigator may refer member to any 4.1 Transportation Services If ESMF says "U" for OPWDD: • Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data • If information is not available in MEVS, Social Care Navigator should ask member if currently enrolled in OPWDD ○ If yes, reach out to OPWDD point of contact (below) to confirm if the member is currently enrolled. Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by OPWDD waiver ○ If no, Social Care Navigator may refer member to any 4.1 Transportation Services Social Care Navigator should confirm with the member their CCO, referencing https://nysemail.sharepoint.com/:b:/r/sites/Healthexternal/SCNLE/Shared Documents/SCN Operations Manual/CCO Coverage Chart.pdf?csf=1&web=1&e=b9uxnm the CCO file on the SCN Lead Entity SharePoint • **ACA:** questions@myacany.org | (833) 692-2269 • **CDNY:** Trisha Chapman | tchapman@caredesignny.org • **LIFEPlan:** questions@lifeplanccony.com | (855) 572-2669 • **PCS:** Kariann Ives | KIves@personcenteredservices.com • **PCC:** Terria Thompson | Terria.Thompson@primecareny.org • **STC:** Jessica Colon | colonj@southerntierconnect.org ***or*** Carey Peters | petersc@southerntierconnect.org • **TCC:** Jennifer Huddleston | j.huddleston@tricountycare.org For any Medicaid member being navigated to Enhanced HRSN Services who is identified as enrolled in a CCO/HH, the Social Care Navigator should contact the member's CCO to ensure awareness of SCN navigation and services and to seek input as appropriate.
Waiver / program: OPWDD **HRSN Category: Housing**		

Relevant services offered via OPWDD Waiver	Details of potential duplication	Guidance for Social Care Navigators
Environmental Modifications: Provides physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home Cap on maximum services over 5-year period (possible for OPWDD care managers to explore opportunity to exceed cap based on member circumstances and need) Implementation of hard service limits will not take effect until on	Member should ONLY receive 2.1 Medically necessary Home Modifications if they have exhausted the OPWDD Waiver cap and have explored pathways with OPWDD to receive additional funds beyond cap Only in very rare circumstances are members expected to exhaust cap	If member has unmet need in housing domain, is eligible for 2.1 Medically necessary Home Modifications are AND… If ESMF says “Y” for OPWDD and member confirms they are receiving services: ● Social Care Navigator should outreach to OPWDD point of contact (below), informing contact of unmet need and confirming that the member has exhausted the cap and explored opportunities to exceed cap ● If yes, Social Care Navigator may refer to 2.1 Medically necessary Home Modifications ● If not, Social Care Navigator should not refer member to additional 2.1 Medically necessary Home Modifications If ESMF says "Y” for OPWDD but member indicates they are not receiving services: ● Social Care Navigator should outreach to OPWDD point of contact (below), informing the program of unmet need and confirming that the member has exhausted the soft cap and explored opportunities to exceed cap ● If yes, Social Care Navigator may refer to 2.1 Medically necessary Home Modifications ● If not, Social Care Navigator should not refer member to additional 2.1 Medically necessary Home Modifications If ESMF says “N” for OPWDD and member confirms they are not receiving services: ● Social Care Navigator may refer to 2.1 Medically necessary Home Modifications If ESMF says “U” for OPWDD: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should outreach to OPWDD point of contact (below), confirming: ○ The member is not enrolled in the OPWDD Waiver currently OR

or after OPWDD has fully expended all available American Rescue Plan Act (ARPA)/Section 9817 funding		○ The member is enrolled in the OPWDD Waiver but has exhausted the full cap and explored opportunities to exceed cap • If one of the above is true, Social Care Navigator may refer to 2.1 Medically necessary Home Modifications • If the member is enrolled in the OPWDD Waiver and has not exhausted the cap or explored opportunities to exceed cap, Social Care Navigator should not refer member to SCN 2.1 Medically necessary Home Modifications and member should continue to access services through OPWDD Social Care Navigator should confirm with the member their CCO, referencing the CCO file on the SCN Lead Entity SharePoint • **ACA:** questions@myacany.org | (833) 692-2269 • **CDNY:** Trisha Chapman | tchapman@caredesignny.org • **LIFEPlan:** questions@lifeplanccony.com | (855) 572-2669 • **PCS:** Kariann Ives | KIves@personcenteredservices.com • **PCC:** Terria Thompson | Terria.Thompson@primecareny.org • **STC:** Jessica Colon | colonj@southerntierconnect.org ***or*** Carey Peters | petersc@southerntierconnect.org • **TCC:** Jennifer Huddleston | j.huddleston@tricountycare.org For any Medicaid member being navigated to Enhanced HRSN Services who is identified as enrolled in a CCO/HH, the Social Care Navigator should contact the member's CCO to ensure awareness of SCN navigation and services and to seek input as appropriate.
Waiver / program: OPWDD **HRSN Category: Housing**		
Relevant services offered via OPWDD Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Community Transition Services for those transitioning from an institutional or provider-operated residence (e.g.,	Members can receive 2.8 CTS only if they have unenrolled from OPWDD Waiver Members **CANNOT** receive OPWDD transitional	If member has unmet need in housing domain, is eligible for 2.8 Community Transitional Supports (CTS), AND… If ESMF says "Y" for OPWDD and member confirms they are receiving services: • Social Care Navigator should not refer the member to 2.8 Community Transitional Supports If ESMF says "Y" for OPWDD but member indicates they are not receiving services:

moving costs, security deposit)	assistance AND 2.8 CTS concurrently	• Social Care Navigator should outreach to OPWDD point of contact (below), and confirm if the member is enrolled in the OPWDD Waiver • If yes, Social Care Navigator should not refer the member to 2.8 Community Transitional Supports • If no, Social Care Navigator may refer to 2.8 Community Transitional Supports If ESMF says "N" for OPWDD and member confirms they are not receiving services: • Social Care Navigator may refer to 2.8 CTS If ESMF says "U" for OPWDD: • The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data • If not, Social Care Navigator should outreach to OPWDD point of contact (below), and confirm if the member is enrolled in the OPWDD Waiver • If yes, Social Care Navigator should not refer the member to 2.8 Community Transitional Supports • If no, Social Care Navigator may refer to 2.8 Community Transitional Supports Social Care Navigator should confirm with the member their CCO, referencing the CCO file on the SCN Lead Entity SharePoint • **ACA:** questions@myacany.org | (833) 692-2269 • **CDNY:** Trisha Chapman | tchapman@caredesignny.org • **LIFEPlan:** questions@lifeplanccony.com | (855) 572-2669 • **PCS:** Kariann Ives | KIves@personcenteredservices.com • **PCC:** Terria Thompson | Terria.Thompson@primecareny.org • **STC:** Jessica Colon | colonj@southerntierconnect.org ***or*** Carey Peters | petersc@southerntierconnect.org • **TCC:** Jennifer Huddleston | j.huddleston@tricountycare.org For any Medicaid member being navigated to Enhanced HRSN Services who is identified as enrolled in a CCO/HH, the Social Care Navigator should contact the member's CCO to ensure awareness of SCN navigation and services and to seek input as appropriate.
Waiver / program: TBI **TBI Waiver eligibility criteria:**		

• Individual must require a level of care equivalent to what is provided in a nursing facility but can live in the community with the appropriate supports • Demonstrated risk of being placed in a nursing home or other institutional setting **HRSN category: Housing**		
Relevant services offered via TBI Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Community Transitional Services	Members can receive 2.8 Community Transitional Supports only if they have exhausted the cap for the TBI Waiver	If member has unmet need in housing domain, is eligible for SCN 2.8 Community Transitional Supports, AND… If ESMF says "Y" for TBI and member confirms they are receiving services: • Social Care Navigator should email TBI Waiver program, informing care manager of unmet need and confirming that the member has exhausted allowable transitional services ○ If yes, Social Care Navigator may refer the member to 2.8 Community Transitional Supports ○ If no, Social Care Navigator should not refer the member to 2.8 Community Transitional Supports If ESMF says "Y" for TBI but member indicates they are not receiving services: • Social Care Navigator should email the TBI program, informing care manager of unmet need and confirming that the member has exhausted allowable transitional services ○ If yes, Social Care Navigator may refer the member to 2.8 Community Transitional Supports ○ If no, Social Care Navigator should not refer to 2.8 Community Transitional Supports If ESMF says "N" for TBI and member confirms they are not receiving services: ● Social Care Navigator may refer to 2.8 Community Transitional Supports If ESMF says "U" for TBI: ● Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should email the TBI Waiver, confirming:

		○ The member is not enrolled in the program OR ○ The member has maximized the program's cap for CTS ● If one of the above is true, Social Care Navigator may refer to 2.8 Community Transitional Supports **TBI Waiver email for Social Care Navigators:** tbi@health.ny.gov
Waiver / program: TBI **HRSN Category: Housing**		
Relevant services offered via TBI Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Environmental Modifications (e.g., ramps, lifts, widened doorways, handrails)	Members can receive SCN 2.1 Medically necessary Home Modifications only if they have exhausted the cap for the TBI Waiver	If member has unmet need in housing domain, is eligible for 2.1 Medically necessary Home Modifications, AND… If ESMF says "Y" for TBI and member confirms they are receiving services: ● Social Care Navigator should email the TBI Waiver program, informing the program of unmet need and confirming that the member has exhausted the full TBI cap ○ If yes, Social Care Navigator may refer to 2.1 Medically necessary Home Modifications ○ If no, the Social Care Navigator should not refer to 2.1 Medically necessary Home Modifications If ESMF says "Y" for TBI but member indicates they are not receiving services: ○ Social Care Navigator should email the TBI Waiver program, informing the program of unmet need and confirming that the member has exhausted the full cap ○ If yes, Social Care Navigator may refer to 2.1 Medically necessary Home Modifications ○ If no, the Social Care Navigator should not refer to 2.1 Medically necessary Home Modifications If ESMF says "N" for TBI and member confirms they are not receiving services: ● Social Care Navigator may refer to 2.1 Medically necessary Home Modifications If ESMF says "U" for TBI: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found,

		proceed with the steps outlined above, replacing ESMF data with MEVS data • If not, Social Care Navigator should email the TBI Waiver program, confirming: ○ The member is not enrolled in the TBI Waiver currently OR ○ They have exhausted the full cap • If one of the above is true, Social Care Navigator may refer to 2.1 Medically necessary Home Modifications • If neither of the options is true, the Social Care Navigator should not refer to 2.1 Medically necessary Home Modifications **TBI Waiver email for Social Care Navigators:** tbi@health.ny.gov
Waiver / program: TBI **HRSN Category: Transportation**		
Relevant services offered via TBI Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Transportation reimbursement for non-medical activities that support the member to live in their community	There is no expenditure cap for TBI transportation services, but transportation needs are typically pre-written into a plan by TBI service coordinator, and this plan may not account for transport to Enhanced HRSN Services Members may receive 4.1 Transportation related to trips / destinations that	If member has unmet need in transportation domain, is eligible for 4.1 Transportation related to HRSN services or care management, AND… If ESMF says “Y” for TBI and member confirms they are receiving services: ● Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by TBI Waiver (i.e., transportation to other Enhanced HRSN Services) If ESMF says "Y” for TBI and member indicates they are not receiving services: ● Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by TBI Waiver (i.e., transportation to other Enhanced HRSN Services) If ESMF says “N” for TBI and member confirms they are not receiving services: ● Social Care Navigator may refer member to 4.1 Transportation If ESMF says “U” for TBI:

	are incremental to what is provided via TBI Waiver (e.g., transportation to Enhanced HRSN Services)	● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should confirm with the TBI program via email if the member is currently enrolled ○ If yes, Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by TBI Waiver (i.e., transportation to other Enhanced HRSN Services) ○ If no, Social Care Navigator may refer member to 4.1 Transportation **TBI Waiver email for Social Care Navigators:** tbi@health.ny.gov
Waiver / program: NHTD Waiver **NHTD Waiver eligibility criteria:** ● Assessed as needing nursing home level of care, and either between the ages of 18-64 and have a verified physical disability OR are age 65 or older when applying to the program **HRSN category: Transportation**		
Relevant services offered via NHTD Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Transportation only for non-medical activities which support the participant's integration into the community	There is no expenditure cap for NHTD transportation services, however, transportation needs are typically pre-written into a plan by NHTD service coordinator and this plan may not account for transport to Enhanced HRSN services	If member has unmet need in transportation domain, is eligible for 4.1 Transportation related to HRSN services or care management, AND… If ESMF says "Y" for NHTD and member confirms they are receiving services: ● Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by NHTD Waiver (i.e., transportation to other Enhanced HRSN Services) If ESMF says "Y" NHTD but member indicates they are not receiving services: ● Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by NHTD Waiver (i.e., transportation to other Enhanced HRSN Services) If ESMF says "N" for NHTD and member confirms they are not receiving services:

	members may receive 4.1 Transportation related to trips / destinations that are incremental to what is provided via NHTD waiver (e.g., transportation to Enhanced HRSN Services)	• Social Care Navigator may refer the member to 4.1 Transportation If ESMF says "U" for NHTD: • The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data • If not, Social Care Navigator should email the NHTD program to confirm if the member is currently enrolled: ○ If yes, Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that are not covered by NHTD Waiver (i.e., transportation to other Enhanced HRSN Services) ○ If no, Social Care Navigator may refer the member to 4.1 Transportation **NHTD Waiver email for Social Care Navigators:** nhtdwaiver@health.ny.gov
Waiver / program: NHTD Waiver **HRSN category: Nutrition**		
Relevant services offered via NHTD Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Nutritional counseling Home delivered and / or congregate meals - up to two meals a day for individuals who cannot prepare or access nutritionally adequate meals for themselves	Members CANNOT receive NHTD nutritional services and 3.1 Nutrition Counseling and Education or 3.2 Medically Tailored or Clinically Appropriate Meals concurrently	If member has unmet need in Nutrition domain, is eligible for SCN 3.1 Nutrition Counseling and Education and/or 3.2 Medically Tailored or Clinically Appropriate Meals, AND… If ESMF says "Y" for NHTD and member confirms they are receiving services: • Social Care Navigator should <u>not</u> refer the member to 3.1 Nutrition Counseling and Education and/or 3.2 Medically Tailored or Clinically Appropriate Meals If ESMF says "Y" for NHTD but member indicates they are not receiving services: • Social Care Navigator should email NHTD Waiver program and confirm if the member is enrolled: ○ If yes, Social Care Navigator should <u>not</u> refer the member to 3.1 Nutrition Counseling and Education and 3.2 Medically Tailored or Clinically Appropriate Meals

		○ If no, Social Care Navigator may refer to 3.1 Nutrition Counseling and Education and 3.2 Medically Tailored or Clinically Appropriate Meals If ESMF says "N" for NHTD and member confirms they are not receiving services: ● Social Care Navigator may refer to 3.1 Nutrition Counseling and Education and 3.2 Medically Tailored or Clinically Appropriate Meals If ESMF says "U" for NHTD: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should email NHTD Waiver program and confirm if the member is currently enrolled: ○ If yes, Social Care Navigator should <u>not</u> refer the member to 3.1 Nutrition Counseling and Education and 3.2 Medically Tailored or Clinically Appropriate Meals ○ If no, Social Care Navigator may refer to 3.1 Nutrition Counseling and Education and 3.2 Medically Tailored or Clinically Appropriate Meals **NHTD Waiver email for Social Care Navigators:** nhtdwaiver@health.ny.gov
Waiver / program: NHTD Waiver HRSN category: Housing		
Relevant services offered via NHTD Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Environmental Modifications for Homes	Members should ONLY receive 2.1 Home Accessibility and Safety Modifications services if they have exhausted services provided via the NHTD Waiver	If member has unmet need in housing domain, is eligible for 2.1 Medically necessary Home and Safety Modifications, AND… If ESMF says "Y" for NHTD and member confirms they are receiving services: ● Social Care Navigator should email NHTD waiver to confirm that the member has exhausted the full Home Modifications cap ○ If yes, Social Care Navigator may refer to 2.1 Medically necessary Home and Safety Modifications

		○ If no, Social Care Navigator should not refer member to 2.1 Medically necessary Home and Safety Modifications If ESMF says "Y" for NHTD but member indicates they are not receiving services: ● Social Care Navigator should email NHTD waiver to confirm that the member has exhausted the full Home Modifications cap ○ If yes, Social Care Navigator may refer to 2.1 Medically necessary Home and Safety Modifications ○ If no, Social Care Navigator should not refer member to 2.1 Medically necessary Home and Safety Modifications If ESMF says "N" for NHTD and member confirms they are not receiving services: ● Social Care Navigator may refer to 2.1 Medically necessary Home and Safety Modifications If ESMF says "U" for NHTD: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should contact NHTD via email, confirming: ○ The member is not enrolled in the waiver OR ○ The member has maximized the waiver cap before referring to SCN 2.1 Medically necessary Home and Safety Modifications ● If one of the above is true, Social Care Navigator may refer to 2.1 Medically necessary Home and Safety Modifications ● If neither of the above is true, Social Care Navigator should not refer member to 2.1 Medically necessary Home and Safety Modifications **NHTD Waiver email for Social Care Navigators:** nhtdwaiver@health.ny.gov
Waiver / program: NHTD Waiver HRSN category: Housing		
Relevant services	**Details of potential duplication**	**Guidance for Social Care Navigators**

offered via NHTD Waiver		
Community Transitional Services	Members should only receive 2.8 Community Transitional Supports only if they have exhausted the cap for the NHTD Waiver	If member has unmet need in housing domain, is eligible for 2.8 Community Transitional Supports, AND… If ESMF says "Y" for NHTD and member confirms they are receiving services: ● Social Care Navigator should email NHTD Waiver to confirm that the member has exhausted allowable transitional services ○ If yes, Social Care Navigator may refer the member to 2.8 Community Transitional Supports ○ If no, Social Care Navigator should not refer the member to 2.8 Community Transitional Supports If ESMF says "Y" for NHTD but member indicates they are not receiving services: ● Social Care Navigator should email NHTD Waiver to confirm that the member has exhausted allowable transitional services ○ If yes, Social Care Navigator may refer the member to 2.8 Community Transitional Supports ○ If no, Social Care Navigator should not refer the member to 2.8 Community Transitional Supports If ESMF says "N" for NHTD and member confirms they are not receiving services: ● Social Care Navigator may refer the member to 2.8 Community Transitional Supports If ESMF says "U" for NHTD: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should email the NHTD waiver, confirming: ○ The member is not enrolled in the program OR ○ The member has maximized the waiver cap before referring to 2.8 Community Transitional Supports ● If one of the above is true, Social Care Navigator may refer to 2.8 Community Transitional Supports **NHTD Waiver email for Social Care Navigators:** nhtdwaiver@health.ny.gov

Waiver / program: Children's Waiver
Children's Waiver eligibility criteria:

- Children/youth who have a physical health, developmental disability, and/or mental health diagnosis
- Also must have related significant needs that place them at-risk of hospitalization or institutionalization or that HCBS is needed for the child/youth to return safely home and to their community from a higher level of care

HRSN category: Housing

Relevant services offered via Children's Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Medically necessary Home Modifications and remediation (e.g., installation of ramps, widening of doorways, specialized electric and plumbing systems) Up to one modification per year	Members should ONLY receive 2.1 Medically necessary Home and Safety Modifications if they have exhausted calendar year cap for Children's Waiver	If member has unmet need in housing domain, is eligible for 2.1 Medically necessary Home and Safety Modifications, AND… If ESMF says "Y" for Children's Waiver and member confirms they are receiving services: ● Social Care Navigator should email Children's Waiver program, informing care manager of unmet need and confirming that the member has exhausted allowable services for the year ● If yes, Social Care Navigator may refer member to 2.1 Medically necessary Home and Safety Modifications ● If no, Social Care Navigator should not refer member to 2.1 Medically necessary Home and Safety Modifications If ESMF says "Y" for Children's Waiver but member indicates they are not receiving services: ● Social Care Navigator should email Children's Waiver program, informing care manager of unmet need and confirming that the member has exhausted allowable services for the year ● If yes, Social Care Navigator may refer member to 2.1 Medically necessary Home and Safety Modifications ● If not, Social Care Navigator should not refer the member to 2.1 Medically necessary Home and Safety Modifications If ESMF says "N" for Children's Waiver and member confirms they are not receiving services: ● Social Care Navigator may refer to 2.1 Medically necessary Home and Safety Modifications If ESMF says "U" for Children's Waiver: ● The Social Care Navigator should email Children's Waiver program, confirming:

		• The member is not enrolled in the Children's Waiver currently OR • The member has exhausted allowable services for the year • If one of the above is true, Social Care Navigator may refer to 2.1 Medically necessary Home and Safety Modifications • If neither is true, Social Care Navigator should not refer the member to 2.1 Medically necessary Home and Safety Modifications **Children's Waiver email for Social Care Navigators:** supportFMS@childrenshealthhome.org Social Care Navigators should include the member's name, DOB, and Medicaid CIN# in outreach
Waiver / program: Children's Waiver **HRSN Category: Transportation**		
Relevant services offered via Children's Waiver	**Details of potential duplication**	**Guidance for Social Care Navigators**
Non-Medical transportation services are available for individuals to access authorized HCBS and destinations that are related to a goal included on the child/youth's POC Examples where this service may be requested include transportation to: HCBS that a	Member may receive 4.1 Transportation related to HRSN services that are incremental to what is provided via Children's waiver (i.e., members can be transported to other Enhanced HRSN Services)	If member has unmet need in transportation domain, is eligible for 4.1 Transportation, AND… If ESMF says "Y" for Children's Waiver and member confirms they are receiving services: • Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that that they are not receiving through the Children's Waiver If ESMF says "Y" for Children's Waiver but member indicates they are not receiving services: • Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that that they are not receiving through the Children's Waiver If ESMF says "N" and member confirms they are not receiving services: • Social Care Navigator may refer the member to 4.1 Transportation If ESMF says "U": • The Social Care Navigator should email the Children's Waiver program to confirm if the member is currently enrolled

child/youth was determined eligible to receive, a job interview, college fair, a wellness seminar, a GED preparatory class, etc.		• If yes, Social Care Navigator may refer the member to 4.1 Transportation for trips / destinations that that they are not receiving through the Children's Waiver • If no, Social Care Navigator may refer the member to 4.1 Transportation **Children's Waiver email for Social Care Navigators:** supportFMS@childrenshealthhome.org Social Care Navigators should include the member's name, DOB, and Medicaid CIN# in outreach
Waiver / program: Healthy Homes **Healthy Homes eligibility criteria:** • The Healthy Homes Program accepted referrals from providers of patients with diagnosed moderate persistent or severe persistent asthma living with mold or pests (mice, rats or cockroaches) in the home **HRSN Category: Housing**		
Relevant services offered via Healthy Homes	**Details of potential duplication**	**Guidance for Social Care Navigators**
Asthma Remediation services (e.g., Mold and Pest Remediation)	Member may receive 2.3 Asthma Remediation services that are incremental to what was provided via Healthy Homes (i.e., members can be transported to other Enhanced HRSN Services)	If member has unmet need in housing domain, is eligible for 2.3 Asthma Remediation, AND… If ESMF says "Y" for Healthy Homes and member confirms they received services: • Social Care Navigator should ask for additional details regarding the type/extent of home improvement services received and may refer the member to 2.3 Asthma Remediation for services they did not receive through the Healthy Homes Pilot If ESMF says "Y" for Healthy Homes but member indicates they did not receive services: Social Care Navigator may refer the member to 2.3 Asthma Remediation If ESMF says "N" and member confirms they did not receive services: Social Care Navigator may refer the member to 2.3 Asthma Remediation

		If ESMF says "U": Social Care Navigator should ask the member: *Did your household receive home improvement services under the NYS Healthy Homes Pilot?* • If yes, Social Care Navigator should ask for additional details regarding the type/extent of home improvement services received and may refer the member to 2.3 Asthma Remediation for services they did not receive through the Healthy Homes Pilot • If no, Social Care Navigator may refer the member to 2.3 Asthma Remediation
Waiver / program: Nutritional Counseling **Nutritional Counseling eligibility criteria:** • A licensed practitioner must recommend the services • The services must be medically necessary **HRSN category: Nutrition**		
Relevant services offered via Nutritional Counseling	**Details of potential duplication**	**Guidance for Social Care Navigators**
Nutritional Counseling	Members can receive 3.1 Nutrition Counseling and Education if they are **NOT** already receiving Nutritional Counseling services provided by MCOs (because they have opted out of services or because they have maxed out	If member has unmet need in Nutrition domain, is eligible for 3.1 Nutrition Counseling and Education, AND… If ESMF says "Y" for Nutritional Counseling and member confirms they are receiving services: ● Social Care Navigator should not refer member to 3.1 Nutrition Counseling and Education If ESMF says "Y" for Nutritional Counseling but member indicates they are not receiving services: ● Social Care Navigator should contact the member's MCO, confirming: ○ The member is not enrolled in the program OR ○ The member has maximized the service duration ● If one of the above is true, Social Care Navigator may refer member to 3.1 Nutrition Counseling and Education

	the service duration)	● If neither is true, Social Care Navigator should not refer member to 3.1 Nutrition Counseling and Education If ESMF says "N" for Nutritional Counseling and member confirms they are not receiving services: ● Social Care Navigator may refer member to nutritional counseling via the 3.1 Nutrition Counseling and Education If ESMF says "U" for Nutritional Counseling: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should contact the member's MCO, confirming: ○ The member is not enrolled in the program OR ○ The member has maximized the service duration ● If one of the above is true, Social Care Navigator may refer member to 3.1 Nutrition Counseling and Education ● If neither is true, Social Care Navigator should not refer member to 3.1 Nutrition Counseling and Education
Waiver / program: Medically Tailored Meals ILOS **HRSN category: Nutrition**		
Relevant services offered via MTM ILOS	**Details of potential duplication**	**Guidance for Social Care Navigators**
Medically Tailored Meals (up to 2 meals daily for six months)	Members can receive 3.2 Medically Tailored or Clinically Appropriate Meals if: 1. They have maxed out service limits for MCO MTM benefit **<u>OR</u>**	If member has unmet need in Nutrition domain, is eligible for 3.2 Medically Tailored or Clinically Appropriate Meals, AND… If ESMF says "Y" for MTM ILOS and member confirms they are receiving services: ● Social Care Navigator should not refer member to 3.2 Medically Tailored or Clinically Appropriate Meals If ESMF says "Y" for MTM ILOS but member indicates they are not receiving services: ● Social Care Navigator should contact the member's MCO, confirming: ○ The member is not enrolled in MTM ILOS benefit OR ○ The member has maximized the service duration (e.g., six months)

	2. If they have unenrolled from their MCO's MTM benefit Members **CANNOT** receive MTM ILOS and SCN 3.2 Medically Tailored or Clinically Appropriate Meals concurrently Members receiving MCO MTMs are able to be referred to other Nutrition services (e.g., 3.1 Nutrition Counseling and Education) as appropriate	● If one of the above is true, Social Care Navigator may refer member to 3.2 Medically Tailored or Clinically Appropriate Meals ● If neither of the above is true, Social Care Navigator should not refer member to 3.2 Medically Tailored or Clinically Appropriate Meals If ESMF says "N" for MTM ILOS and member confirms they are not receiving services: ● Social Care Navigator may refer member to 3.2 Medically Tailored or Clinically Appropriate Meals If ESMF says "U" for MTM ILOS: ● The Social Care Navigator should first check the MEVS to verify if enrollment data is available. If enrollment data is found, proceed with the steps outlined above, replacing ESMF data with MEVS data ● If not, Social Care Navigator should contact the member's MCO, confirming: ○ The member is not enrolled in MTM ILOS OR ○ The member has maximized the service duration (e.g., six months) ● If one of the above is true, Social Care Navigator may refer member to 3.2 Medically Tailored or Clinically Appropriate Meals ● If neither of the above is true, Social Care Navigator should not refer member to 3.2 Medically Tailored or Clinically Appropriate Meals

6. PERFORMANCE

Performance and payment sub-sections:

a. Overall Approach to Performance Management

b. SCN Lead Entity Reporting

a. OVERALL APPROACH TO PERFORMANCE MANAGEMENT

The SCN program will involve many organizations who have either not participated in Medicaid before or who will take on new roles and responsibilities. As a result, as the program is launched, performance management will be particularly important to ensure that issues and opportunities for improvement are quickly and consistently addressed via a collaborative process.

Performance management will be a collaboration between OHIP and SCN Lead Entities. OHIP's goal is to enable timely and actionable improvements for SCNs to achieve 1115 Waiver objectives. Performance management reports will help facilitate ongoing engagement between OHIP and SCN Lead Entities.

As part of the performance management approach, SCN Lead Entities will be responsible for generating specific inbound reports (*see SCN Reporting for additional details*) both before program start and on an ongoing basis. Complementing these SCN-generated reports will be a set of OHIP-generated outbound reports. These outbound reports from OHIP will provide SCN Lead Entities with transparency into their performance (and peer performance) and enable continuous performance improvement.

In addition to the planned reporting, SCN Lead Entities will be expected to submit real-time updates to OHIP to enable timely assessment and management of SCN operations. The real-time updates include but are not limited to network changes, governing body changes, and changes to SCN Lead Entity financials.

i. Performance Management Systems, Processes, and Validation

The SCN Lead Entity will report relevant performance metrics in accordance with detailed templates and metric definitions provided by OHIP. Select metrics and reports are detailed in this Operations Manual, and others will be outlined in additional materials provided at a later date. OHIP will review these reports to confirm accuracy and identify potential reporting issues to resolve with the SCN.

Detailed Business Requirements (DBRs) for each relevant metric – including definitions of the metric, inclusion and exclusion criteria, time ranges for reporting, etc. – will be provided to SCN Lead Entities in an instruction manual, and relevant updates will be communicated as needed to ensure accurate reporting. Reporting templates will also be provided to ensure consistent report format across all SCNs.

Inbound reports from SCN Lead Entities to OHIP will be submitted through an Excel sheet or other specified format in the Health Commerce System or other specified submission process. Outbound reports from OHIP to SCN Lead Entities will be transmitted through email attachment or Secure File Transfer Protocol (SFTP) for the SCN Lead Entity to access.

During the initial implementation phases, there will be a need for interim aggregate-level reporting before data integration into the data lake is complete and as necessary systems, including vendor alignment, are

established. Early performance management reports will focus on basic operations and network composition and then will gradually shift to include metrics focused on efficient operations, service excellence, and benchmarking across SCN entities.

OHIP will review reports to confirm their accuracy and identify potential reporting issues to resolve with the SCN Lead Entity. For selected identified metrics that are calculated by SCN Lead Entities and available to OHIP through data aggregated into OHIP's Medicaid Data Warehouse (MDW), metrics will be reviewed and cross-validated to ensure accurate reporting. Any cross-validated metrics that have a significant discrepancy (greater than 5-10% from original submission) will be flagged by OHIP and discussed during the performance management meetings described below. The SCN Lead Entity will have an opportunity to resubmit amended data in case of discrepancies due to error and/or other reporting issue.

Cadence of Performance Management Engagement: Performance management discussions will occur regularly.

OHIP may also request ad hoc meetings with SCN Lead Entities as needed. During these performance discussions, OHIP contract managers will review monthly performance reports and discuss with the SCN Lead Entities any identified issues and successes. Contract managers will support SCN Lead Entities with performance improvement should performance concerns be identified.

Further Actions on Performance Management: Based on performance management reports and discussions, OHIP may implement certain levers to support and assist the SCN, including tools for analysis, management, data analysis, and consulting.

Additionally, OHIP will establish certain benchmarks for performance management metrics. If the SCN does not meet the listed benchmarks, OHIP may provide short-term increased technical assistance to improve the metric outcome. If SCN Lead Entities have consistent issues with performance management, OHIP may require increased frequency of touchpoints between SCN Lead Entities and OHIP contract managers, and enhanced analysis of SCN data.

For any performance management issues that the SCN does not have direct control over – such as HRSN service provider operations or relationships with regional networks and other partners – OHIP may be able to provide direct outreach to help alleviate issues. For direct SCN Lead Entity performance management issues – such as internal data processing, staffing, or training / onboarding - OHIP will work directly with the SCN Lead Entity.

Select Performance Operating Report Metrics: OHIP plans to monitor performance using a set of key metrics. Below are a set of proposed key operating metrics that may be used to assess SCNs on their performance through monthly monitoring and reporting. The final list of metrics will be communicated to SCN Lead Entities by their contract manager.

Metrics marked with two asterisks (**) are metrics also calculated by the SCN Lead Entity and submitted through the Weekly Operational Indicator Survey. Those metrics not marked with an asterisk may be calculated by OHIP and shared with SCN Lead Entities during regular performance management meetings.

Metrics

Member Engagement:

- **Incoming member inquiries (#)
- Outbound member outreach (#)

HRSN Screening:

- **Members screened (#, %)
- **Members screened on or off platform (#)
- ** Members that decline consent (#, %)
- **Members with a positive screen on or off platform (#)
- Screening results by HRSN domain (#, %)
- Screenings with complete demographics (% of Screenings)
- Screening modality (% of Screenings- virtual, phone, % in person)
- Screenings outside of business hours (#, % of Screenings)
- Members re-screened within the year (#)
- Members with an unmet HRSN (as determined by Screening) successfully contacted for an assessment within 5 business days

Eligibility Assessment:

- **Members assessed (#, %, Retention %)
- **Member for whom Eligibility Assessment outreach was exhausted (#)
- Members assessed by HRSN domain (#, %)
- Eligibility Assessment criteria response type by SNOMED/ICD10 Code (as % of Screens that identify an unmet HRSN)
- **Individuals eligible for HRSN services who decline Eligibility Assessment~~services~~ (#, % of members)
- Individuals eligible for Enhanced HRSN Services by Enhanced Services Population (#, ID'd by SCN)
- Members assessed by clinical criteria (#, ID'd by SCN)
- Members assessed by duplicated service (#, ID'd by SCN)

Referral:

- **Members referred (#, %, Retention %)
- **Members who decline referral (#)
- Members referred by HRSN domain (#, %)
- Members referred within 7 business days (%)
- Referrals made that are accepted within 5 business days (%)
- Social Care Plans created (#)
- Referral backlog volume (# referrals outstanding TBD business days, %)
- Referral follow-ups initiated by SCNs (#)
- Referrals rejected by HRSN Service Providers (#, %)
- Members navigated to WIC (DOH), TANF and SNAP (OTDA) (#)
- **Members navigated to existing local, state and federal housing using SNOMED coding (#)
- Members receiving Navigation for non-enhanced domains, by service type (#,%)
- Members with identified unmet HRSNs in their Screening who are navigated to existing federal state, and local programs within 7 business days (%)

Intervention / Service Delivery:

- **Members for whom a service is initiated (#, %, Retention %)

- Closed Loop Referral rate (% of referrals)
- Members with services completed (#, %)
- Members for whom a service is initiated, by HRSN domain (#, %)
- Members with services completed, by HRSN domain (#, %)
- Re-authorization of Enhanced HRSN Services (% of relevant Enhanced HRSN Services that are re-authorized)
- Accepted referrals for which a service is initiated within 2 business days (%)
- Members lost to follow up (# who initiate but do not complete)
- Members withdrawing from Enhanced HRSN Services (#)

Network:

- **Size of Social Care Network (#)
- **Composition of Social Care Network (#)
- HRSN service provider utilization by Enhanced HRSN Services in region

Operational Efficiency:

- SCN data submitted to QE within 5 business days (%)
- Payments to HRSN service providers within 30 business days (%)

Metric benchmarks will be developed after SCNs begin to deliver HRSN services. Once established, benchmarks will be leveraged to assess SCN performance relative to defined thresholds and to compare performance across SCN entities.

b. SCN LEAD ENTITY REPORTING

The SCN Lead Entity will submit various reports throughout their contract period to demonstrate effectiveness, timeliness, data integrity, security, and milestones. OHIP or their designated contractors may, at their discretion, access the SCN IT Platform to query for required metric reports that do not contain PHI or clinical level information if deemed necessary.

Table 6-1 provides a summary of reports. The final and most updated reporting templates and instructions for SCN Lead Entities will be rolled out as they are available and made accessible via a link to SCN Lead Entities.

The following sections outline details for each report, including report description and objectives, report metrics, details, and SCN implications, and submission details.

Submission process for all reports: SCN Lead Entities must submit their reports to their designated SharePoint page. The Lead Entity must direct any requests to add or delete SharePoint users to their assigned OHIP contract manager.

Table 6-1: Overview of major reports

Report Name	Description	Cadence
1. Quarterly Performance Report	Report will reference the progress made during the last quarter (including Work	Initial submission due on November 30, 2024;

Report Name	Description	Cadence
	Plan Performance Measures) and includes a series of questions related to Objectives	Thereafter, due 1 month after the end of each quarter: • February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)
2. Weekly Performance Management Report *(Operational Indicator Survey)*	Report of HRSN Screenings, Eligibility Assessments, referrals, and service delivery metrics, in addition to limited metrics for network and operational efficiency	February 2, 2026, and each week thereafter
3. Governing Body Report	Report detailing governing body selection and, if needed, resubmission with any updates to the contract manager	One-time initial submission due on November 30, 2024; resubmitted as needed
4. Network Composition Plan and Report	Report of network composition and quarterly reports to maintain and monitor network adequacy	Initial submission due on November 30, 2024; Thereafter, due 1 month after the end of each quarter: • February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)
5. Infrastructure Cost Report	Report containing the BSROE (Budget Statement Report of Expenditures) spreadsheet, including expense checklist by category and tracking the spend of infrastructure and CBO Capacity funding	Initial submission due on November 30, 2024; Thereafter, due 1 month after the end of each quarter from Program Year 1 through Program Year 2 Quarter 3:

Report Name	Description	Cadence
		• February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period) • Following Program Year 2 Quarter 3 Infrastructure Cost Report (ICR) submissions on May 31, 2026, ICRs will be due 10 days after the end of each month for the remainder of the program (June 10, 2026 and monthly thereafter).
6. Budget Reassessment Report	Report of SCN re-assessment of current staffing and infrastructure needs and submission of Budget Modification, if applicable	New Year Template due by May 31, 2025, and annually thereafter. Budget Modification Template due on an as needed basis.
7. Member Experience Survey Report	Report of member satisfaction with screening, navigation, care management, and provision of HRSN Enhanced Services	Initial submission due on February 28th, 2026; thereafter, due one month after the end of each quarter: • February 28 (Nov-Jan reporting) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)

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Report Name	Description	Cadence
8. Member Complaint Report	Report of member complaints on the provision of services, activities, or benefits by the SCN program	Initial submission due on May 31, 2025. Thereafter, due one month after the end of each quarter: • February 28 (Nov-Jan reporting) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)
9. PMPM Cost Report	Report of PMPM revenue received by SCNs including administrative funds and report on use of funds for HRSN service expenses~~.~~	Initial submission is due on April 30, 2026, and will include data for: • Program Year 1 (August 1, 2024, ~~through~~ July 31, 2025) ~~and~~ • Program Year 2 Quarters 1 and 2 (August 1, 2025 ~~through~~ January 31, 2026) Thereafter, submissions will be due one month after the end of each program quarter: ~~(in line with other required reports)~~: • February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)

i. Quarterly Performance Report

Report Description and Objectives: The purpose of the Quarterly Performance Report is for SCN Lead Entities to provide a narrative report on their overall performance and relevant performance measures and tasks. The Quarterly Performance Report will contain narrative on the progress made during the last quarter (including Work Plan Performance Measures) and include a series of questions related to Objectives.

Report Metrics and Details: The Quarterly Performance Report will include SCN successes and accomplishments, as well as any obstacles the SCN has faced and the steps they have taken to overcome obstacles. Additional information will be requested for SCN Lead Entities to detail progress towards ensuring all relevant trainings are provided to SCN Lead Entity employees, HRSN service providers, etc.

Submission Details: Submission deadline of 1 month after end for each quarter (August-October, November-January, February-April, May-July). Quarterly Performance Reports will be submitted using an OHIP-provided Word template.

Table 6-2: Quarterly Performance Report required components

Report sections – subject to change per OHIP	
Category	**Component**
Member Marketing and Engagement	• Overview of your approach • Summary of the key initiative(s) • Impact(s) (both qualitative and quantitative) • Lessons learned that will inform future approach (or best practices that could be shared with other SCN LEs)
Screening	
Navigation	
HRSN Network Building and Service Delivery	
Infrastructure Funding / CBO Capacity Funding	
IT and Technology Infrastructure	• SCN IT platform identification & functionality • Authorized user onboarding • 1115 SHIN-NY Interoperability Guidance[3] • Privacy, security, and compliance requirements
Network Administration, Capacity Building, and Partnerships	• Staff hiring & onboarding • MCO contracts • CBO performance evaluation
HRSN Screening and Service Delivery	• Social care claims submission process • Medicaid members screened

[3] SCN Lead Entities and their IT Platform partners can access more information at https://www.nyehealth.org/1115-waiver/ or on NYeC's NYHER 1115 Extranet

Report sections – subject to change per OHIP	
Category	**Component**
Documentation and Performance Reporting Submission	• Summary update of main report submissions and adherence to standards

ii. Performance Management Report (Weekly Operational Indicator Survey)

Report Description and Objectives: This report contains numerous metrics aimed at assessing the impact of the SCN program on members through Screenings, Eligibility Assessments, referrals, and HRSN services. Additionally, select measures related to network and operational efficiency will be requested. The goal of this report is to assess the extent to which SCNs are reaching and providing services to members within their respective regions and to provide a pulse check to understand operational blockers.

If the organization serving as the SCN Lead Entity is the SCN Lead Entity for multiple regions, the Operational Indicator Survey must be broken down by assigned region and not submitted as aggregate. A separate response is required for each region.

Reporting Metrics: SCN Lead Entities are encouraged to work with their IT platform vendors and technical analysts to provide the metrics requested. A set of instructions has been provided to ensure standard submissions across SCN Lead Entities.

These instructions will contain definitions of the metric, inclusion and exclusion criteria, time ranges for reporting, etc. SCN Lead Entities will be notified if any updates are made to the required metrics within the Operational Indicator Survey. A reporting template will also be provided to ensure consistent report format across all SCN Lead Entities.

Submission Details: Submissions are due by 12PM ET on Mondays for cumulative data collected since January 1, 2026 through 12PM ET the Friday prior. The Operational Indicator Survey will be due weekly beginning February 2, 2026. The first submission on February 2, 2026 will include cumulative data from January 1, 2026 through January 30, 2026. Operational Indicator Surveys will be submitted using an OHIP-provided Excel template via the SCN LE SharePoint.

Table 6-3: Weekly Operational Indicator Survey Metrics

Metrics SCNs will submit on Weekly Operational Indicator Survey– subject to change per OHIP	
Category	**Metric**
Member Engagement	• Incoming member inquiries (#)
HRSN Screening	• Members screened, on platform (#) • Members screened, off platform (#) • Members that decline consent (#) • Members with a positive screen, on platform (#)

	• Members with a positive screen, off platform (#)
Eligibility Assessment	• Members assessed (#) • Members for whom Eligibility Assessment outreach was exhausted (#) • Members who decline Eligibility Assessment (#)
Referral	• Members referred to Enhanced HRSN Services (#) • Members navigated to existing federal, state, & local services (#) • Members who decline referral (#)
Intervention / service delivery	• Members for whom a service is initiated (#)
Network capacity and access	• Size of Social Care Network (#) • Social care Navigator FTEs within network overall (#) • Social Care Navigator FTEs in Network employed by the SCN LE (#

iii. Governing Body Report

Report Description and Objectives: The purpose of the Governing Body Report is to define organizations and relevant governing body members represented in each region.

It is acceptable if the SCN Lead Entity has a unique board for its overall organization that is separate from the SCN Governing Body or modifies their current board to meet the requirements. There is no minimum or maximum number of individuals for the entire governing body; however, SCN Lead Entities will need to follow the minimum allotments and percentages per type of governing body participant.

SCN Lead Entities that were awarded more than one region (e.g., NYC boroughs) must indicate on their Governing Body Report which Board member represents each awarded region.

After submitting the Initial Governing Body Report, the SCN Lead Entity will subsequently convene the governing body at routine intervals or on an ad-hoc basis.

Report Metrics and Details*:* The SCN Lead Entity shall initially select the governing body prior to service start date and shall include the requirements listed in Table 6-4 in their submission.

Submission Details: The submission deadline for this report was November 30, 2024, and updates are to be resubmitted as needed. Governing Body Reports will be submitted using an OHIP-provided Excel template.

This report does not need to be resubmitted to the SCN Lead Entity's contract manager unless there are significant changes to the governing body members. Any changes to the governing body may be sent to OHIP via email or letter including the change of name and title on a real-time basis (as needed).

Table 6-34: Governing Body Report required components

Required components – subject to change per OHIP	
Category	**Component**
Governing Body Members	• Organization / member name • Member role & responsibilities

	• Stakeholder group ○ CBO, Department of Social Services, Medicaid member, Community advocate, health care (physical and behavioral health) and care management providers, other organizations with vested interest in a neighborhood or community and advocates for underserved populations within that community
Governing Body Requirements	• Confirmation that the body meets the following requirements: ○ CBOs shall represent at least fifty-one percent (51%) of members within the governing body (excluding the Lead Entity in the calculation) and have majority share in voting rights ○ Includes CBOs with at least one (1) service location in the SCN's region ○ Includes at least one (1) HRSN service provider with mental health and SUD experience ○ Includes at least two (2) current Medicaid members with HRSN experience

iv. Network Composition Plan and Report

Report Description and Objectives: As part of the RFA scoring process, SCN Lead Entities submitted a Proposed Network Composition Plan to address gaps (RFA's Attachment J). An updated Network Composition Plan was due for submission by November 30, 2024 to the contract manager of the SCN Lead Entity. Moving forward, SCN Lead Entities will submit a comprehensive quarterly Network Composition Report detailing the network to assess for adequacy.

The Network Composition Plan and Report are split across relevant HRSN categories: Care Management, Housing and Utilities, Nutrition, and Transportation.

Report Metrics and Details: (*For more information on network composition metrics, (see HRSN Network Capacity and Access*). The components listed in Table 6-5 are required to be included in the Proposed Plan.

The Network should be inclusive of all Enhanced HRSN Services. Additionally, providers included should be capable of providing the Enhanced HRSN Services listed under Care Management for the Enhanced HRSN Services Population, including those listed below.

Submission Details: The submission deadline for this Network Composition Plan was November 30, 2024. The quarterly Network Composition Report submission deadline is 1 month after the end of each quarter (August-October, November-January, February-April, May-July). Both the Network Composition Plan and Network Composition Reports will be submitted using an OHIP-provided Excel template.

Table 6-5: Network Composition Plan and Report required components

Required components – subject to change per OHIP	
Category	**Component**
HRSN service providers	• List of all HRSN service providers by HRSN category: Care Management, Housing and Utilities, Nutrition, and Transportation • FEIN and address of HRSN service provider • NPI of HRSN service provider, if applicable

	• Entity types for HRSN service providers • Designation to screen by HRSN service provider • Modalities used for Screening by HRSN service provider • Designation of HRSN service providers to conduct Eligibility Assessment and Navigation • HRSN service provider annual budget of less than $5 million • When HRSN service provider was added or removed from Network • If HRSN service provider has completed all required trainings • HRSN service provider interest in Infrastructure Capacity Building Funding and if HRSN service provider has received Capacity Building Funding. • County or counties served by HRSN service provider • Services to be provided by HRSN service provider for each HRSN service domain

v. Infrastructure Cost Report

Report Description and Objectives: The SCN Lead Entity is required to submit an Infrastructure Cost Report on a quarterly basis through Program Year 2 Quarter 3, and monthly beginning in Program Year 2 Quarter 4. This report assesses expenditures across relevant infrastructure categories and includes a detailed checklist of expenses categorized by type of spending. Additionally, it provides a summary-level Budget Statement and Report of Expenditures (BSROE). This report will be used to monitor infrastructure funding spending and track expenditures against the SCN's approved budget. Furthermore, it will also account for spending by CBOs related to Infrastructure Capacity Building Funding.

Report Metrics and Details: Detailed expenses are broken down in expense checklists by type (salary, contractual, travel, equipment, space & property, utilities, operating, other). These expenses by quarter and/or by month will then be aggregated into the BSROE view to assess spend relative to contract period approved budgets. Expenses will further be totaled by relevant infrastructure category.

SCN Lead Entities are required to report additional details on CBO Capacity Funding found under the Capacity Funding tab. This includes the amounts of Capacity Building Funding awarded and allocated to contracted 501(c)(3) or 501(c)(4) CBOs within the Network, as well as identifying information of the CBO and the uses of funds.

Submission Details: Submission deadline is 1 month after the end of each quarter (August-October, November-January, February-April, May-July) through Program Year 2 Quarter 3, and 10 days after end of each month (June 10, July 10, etc.) beginning in Program Year 2 Quarter 4. The Infrastructure Cost Report will be submitted using an OHIP-provided Excel template through specific SharePoint pages designed for each entity.

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Contract managers will review the Infrastructure Cost Report for accuracy. Once the Report is approved, the SCN will be contacted by their Contract Manager to submit a Claim for Payment. The Report must follow the Excel template provided by OHIP, and it is important not to alter any formulas in the Excel file.

Table 6-~~46~~: Infrastructure Cost Report required components

Components – subject to change per OHIP	
BSROE Component	
Overall	• Personnel Services Detail ○ Title, Salary, Approved budget Amount, Expenditures by quarter and/or by month depending on reporting period, Total expenditures to date, Remaining balance, and Fringe • Non-Personnel Services Detail ○ Budget & expenditures by quarter and/or by month depending on reporting period, to date, and Remaining balance ▪ Contractual Services, Travel, Equipment, Space / Property expenses, Rent / Own, Utility, Operating, and Other expenses
Infrastructure Cost Component *The submission of the ~~Quarterly~~ Infrastructure Cost Report will include the following Infrastructure-only expenses that the SCN Lead Entity must document and include specifics on allocation amounts paid across infrastructure / capacity building funding in high-level categories:*	
Data / IT	• People (Salaried or vended) for Data / IT • Vendor • Software / hardware • Set-up costs for Procurement • Implementation of SCN IT Platform • Build out of SCN IT Platform
Network and partnership / communication	• People (salaried or vended) • Materials • Initial network set-up • Partner engagement • CBO capacity building and technical assistance
Screening and service delivery coordination	• People (salaried or vended) • Hiring / recruiting • Salaries + benefits for new positions (until MCO contracts are in place and PMPM payments begin)
Contracting and fiscal management	• People (salaried or vended) • Administration of contracts (MCO + HRSN provider contracts)
Other administrative expenses	• People (salaried or vended) • Hiring / recruiting • Salaries + benefits for new positions (until MCO contracts are in place and PMPM payments begin) • Training and education
Physical space	• Real estate • Utilities

Components – subject to change per OHIP	
	• Set-up of physical space (does not include expenses for creating and constructing a new building per CMS "brick and mortar")

vi. Budget Reassessment Report

Report Description and Objectives: SCN Lead Entities will submit a detailed Budget Reassessment Report within each new year and make modifications to existing budgets previously approved. Detailed line items in this report focus on both personnel and non-personnel services.

Report Metrics and Details: Across all relevant categories, SCN Lead Entities should submit specific budget line items, current budget, proposed budget, net changes, and justifications for the change. This includes when an SCN Lead Entity is submitting the Budget Modification Template or the New Year Budget Template. For Personnel Services, detailed position responsibilities, salaries, work weeks, FTE %, and months funded are required. Additional details can be found in Table 6-7.

Submission Details: The submission deadline for the New Year Budget Template was May 31, 2025 and annually by May 31 thereafter. The Budget Modification Template will be submitted on an as needed basis. Budget Reassessment Reports will be submitted using an OHIP-provided Excel template.

Table 6-7: Budget Reassessment Report required components

Annual metrics – subject to change per OHIP	
Category	**Component**
New Year Budget Template and/or Budget Modification Template	• Personnel Services Detail ○ Position Title ○ Current & Proposed Amounts ▪ Salary, Work Week, FTE %, Months Funded, Budgeted Amount, Fringe Benefits, Net Change ○ Justification, Calculation, and Reason for Change • Non-Personnel Services Detail ○ Budget Line Items ○ Current & Proposed Budget, Net Change ▪ Contractual Services, Travel, Equipment, Space / Property Expenses Rent / Own, Utility, Operating, and Other Expenses ○ Justification, Calculation, and Reason for Change • Total & Proposed Contract Year Budget Totals

vii. Member Experience Survey

Member satisfaction is a key component of SCN performance and a priority of the SCN program. SCNs are expected to solicit member feedback on a regular basis and at the end of service delivery and commit to

continuous improvement to be responsive to member feedback. SCN Lead Entities will also be responsible for responding to members' complaints, in an effort to improve member satisfaction.

Report Description and Objectives: The SCN Lead Entity is required to administer and submit results from the Member Experience Survey on a recurring basis. SCNs are expected to solicit member feedback at the end of service delivery and commit to continuous improvement to be responsive to member feedback.

Report Metrics and Details: The Member Experience Survey report will include member-level survey results across all required questions.

Submission Details: The submission deadline for the Member Experience survey report was February 28, 2026 and subsequently 1 month after end for each quarter (August-October, November-January, February-April, May-July). The Member Experience survey report will be submitted using an OHIP-provided Excel template.

Table 6-8: Member Experience Survey Report components

Report sections—subject to change per OHIP	
Category	**Component**
Required questions	• Feedback on Screening, Navigation, Care Management, and HRSN Enhanced Services • Demographics and Services Received
Recommended optional questions	Additional comments on Screening, Navigation, Care Management, HRSN Enhanced Services, and awareness of program

Member Experience Survey

All SCN Lead Entities will be required to administer a member experience survey using the OHIP Member Experience Survey template. Required questions (and respective response options) must be included in SCN Lead Entity's survey exactly as written. Results must be shared with OHIP as part of quarterly reporting and are due one month after the end of each quarter. The primary intent of soliciting feedback is to understand satisfaction for FFS and MMC members receiving Enhanced HRSN Services. SCN Lead Entities will collect data in a method that is sensitive, culturally appropriate, and accessible to a wide variety of members.

OHIP requires that SCN Lead Entities offer a Member Experience Survey to each member within 30 days of the conclusion of their services (e.g., after a member received Navigation to existing federal, state, and local services, a Home Modification, or 6 months of Medically Tailored Meals). In general, SCNs should send the survey to members after the last service is provided (i.e., if member receives multiple services, send after completion of the last service). SCN Lead Entities are also encouraged to gather responses from members throughout their journey as they receive services, inclusive of Screening, Navigation, and Enhanced HRSN Services. The member experience survey should be offered through multiple methods and using an online survey tool is recommended. OHIP requests that member-level survey responses are shared using the OHIP-provided template so that the State can support SCNs with improving program operations and can help translate learnings between regions. SCN Lead Entities will de-identify survey responses (e.g., removing zip codes, IP addresses) and PHI before submitting data to OHIP. As needed, OHIP may guide SCN Lead Entities to establish a

Performance Improvement Plan to strengthen member experience. SCN Lead Entities must request consent from members to agree to participate in the survey and permission to reach out for follow-ups.

- **The required questions below must be incorporated** into the member experience survey to enable consistent data collection across the State. SCN Lead Entities may also include additional questions in their surveys.

1. **On a scale from 1 to 5, where 1 is very poor and 5 is excellent, how would you rate your experience while completing your Screening for health-related social needs (this includes your understanding of the questions presented, your satisfaction with the Screener or online submission, etc.)?**
    - *1*
    - *2*
    - *3*
    - *4*
    - *5*
    - *Not sure*
2. **On a scale from 1 to 5, where 1 is very poor and 5 is excellent, how would you rate your experience with your Social Care Navigator(s) (this individual helped determining your eligibility for services and referred you to those services)?**
    - *1*
    - *2*
    - *3*
    - *4*
    - *5*
    - *Not sure*
3. **On a scale from 1 to 5, where 1 is very poor and 5 is excellent, how would you rate your experience with the care management you received (such as repeated interactions with a Social Care Navigator to coordinate services like home modifications, temporary housing, or transportation)?**
    - *1*
    - *2*
    - *3*
    - *4*
    - *5*
    - *Not sure*
4. **On a scale from 1 to 5, where 1 is very poor and 5 is excellent, how would you rate your experience with your nutrition service provider?**
    - *1*
    - *2*
    - *3*
    - *4*
    - *5*
    - *Not sure*
    - *I did not receive this service*

5. **On a scale from 1 to 5, where 1 is very poor and 5 is excellent, how would you rate your experience with your housing service provider?**
    - *1*
    - *2*
    - *3*
    - *4*
    - *5*
    - *Not sure*
    - *I did not receive this service*
6. **On a scale from 1 to 5, where 1 is very poor and 5 is excellent, how would you rate your experience with your transportation service provider?**
    - *1*
    - *2*
    - *3*
    - *4*
    - *5*
    - *Not sure*
    - *I did not receive this service*
7. **Please indicate your level of agreement with the following statements…**
    - My Social Care Navigator listened to me and fully understood my needs
        - *a. Agree*
        - *b. Disagree*
        - *c. Not sure*
    - My Social Care Navigator helped me understand what services I could receive and how to access them
        - *a. Agree*
        - *b. Disagree*
        - *c. Not sure*
    - The nutrition services I received fully met my need(s)
        - *a. Agree*
        - *b. Disagree*
        - *c. Not sure*
        - *d. I did not receive this service*
    - I am happy with the quality of nutrition services I received
        - *a. Agree*
        - *b. Disagree*
        - *c. Not sure*
        - *d. I did not receive this service*
    - The housing services I received fully met my need(s)
        - *a. Agree*
        - *b. Disagree*
        - *c. Not sure*
        - *d. I did not receive this service*

- I am happy with the quality of housing services I received
  - *a. Agree*
  - *b. Disagree*
  - *c. Not sure*
  - *d. I did not receive this service*
- The transportation services I received fully met my need(s) received
  - *a. Agree*
  - *b. Disagree*
  - *c. Not sure*
  - *d. I did not receive this service*
- I am happy with the quality of transportation services I received
  - *a. Agree*
  - *b. Disagree*
  - *c. Not sure*
  - *d. I did not receive this service*

- **Survey responses must be linked to demographic data and services received.** SCNs have several options for how to achieve this, including (1) asking the questions below as part of the survey, or (2) linking data to survey responses through the SCN IT Platform or MVD.

1. Are you a Medicaid Fee-For-Service or Medicaid Managed Care member?
   - *Medicaid Fee-For-Service member*
   - *Medicaid Managed Care member*
   - *I don't know*
2. What services have you received from [SCN name] Social Care Network? (Checkboxes)
   - *Screening*
   - *Navigation*
   - *Nutrition services, such as pantry stocking, nutritional classes, or medically tailored meals*
   - *Housing services, such as home modifications, temporary housing, or utility set-up assistance*
   - *Care management, such as repeated interactions with a Social Care Navigator to coordinate services like home modifications, temporary housing, or transportation*
   - *Transportation services*
   - *I have not received any services*
   - *I don't know*
3. What is your age?
   - *0-6*
   - *7-18*
   - *19-64*
   - *65+*
   - *Unknown*
4. What is your gender?
   - *Female*
   - *Male*
   - *Other*
   - *Unknown*
5. Are you of Hispanic or Latino origin or descent?

- *Yes*
- *No*
- *I don't know or prefer not to disclose*

6. What is your race?
    - *American Indian or Alaska Native*
    - *Asian*
    - *Black or African American*
    - *Native Hawaiian or Other Pacific Islander*
    - *White*
    - *I don't know or prefer not to disclose*

- **Recommended optional questions** can be helpful for SCN Lead Entities to learn more about member experience and satisfaction. Examples of optional questions (with freeform response) are:

1. Is there anything you would like to share about the screening you received?
2. Is there anything you would like to share about the navigation services you received?
3. Is there anything you would like to share about the care management services you received?
4. Is there anything you would like to share about the nutrition services you received?
5. Is there anything you would like to share about the housing services you received?
6. Is there anything you would like to share about the transportation services you received?
7. How did you find out about your SCN?
    - *Friends and Family*
    - *Healthcare provider*
    - *Local Event*
    - *Other*

Survey administration requirements

SCN Lead Entities must offer a member experience survey to each member (FFS and MMC members) within 30 days of the conclusion of their services (e.g., after a member received navigation to existing federal, state, and local services, a home modification, or 6 months of medically tailored meals). In general, SCNs should send the survey to members after the last service is provided (i.e., if member receives multiple services, send after completion of the last service). SCNs must request consent from members to agree to participate in the survey and permission to reach out for follow-ups.

Member survey design and implementation

- **Survey audience and cadence:** SCNs are required to solicit member feedback for members receiving services. SCNs are also expected to: gather feedback from members who only received Screening or Navigation, in addition to members who have received Enhanced HRSN Services; and gather interim feedback throughout a member's journey, in addition to post-service.
- **Survey channels**: OHIP encourages SCNs to use multiple survey channels to increase accessibility and participation. At a minimum, this includes options for both synchronous (in person, via phone) and asynchronous (online form) survey completion. SCNs may consider mobile-friendly / chat-based interfaces if possible. SCNs are encouraged to leverage their IT Platforms to support survey administration, including to link member responses to demographic data.
- **Inclusive and accessible surveys**: Surveys should be designed and fielded in a sensitive, culturally appropriate, and accessible way. This includes but is not limited to using plain language that is clear and easily

understandable and providing surveys in non-English languages (e.g., most commonly spoken languages among Medicaid populations in the region). Guidance for translating surveys is available here: https://www.ahrq.gov/cahps/surveys-guidance/helpful-resources/translating/index.html.**Survey length and layout:** Survey layout can improve response rates, ease of completion, and accuracy of responses. Wherever possible, surveys should:

  - Be as brief as possible and cover only the most critical questions that will provide the information SCNs need to improve member experience
  - Segment surveys into multiple sections to demonstrate transition between different question themes and break up survey length
  - Maximize readability through simple language, accessible fonts, and ample white space

- **Consistent training of survey administrators:** Lead Entities should establish clear processes for how to administer the survey and should train everyone administering the survey on those processes. Lead Entities may want to provide instructions on the process steps to conduct the survey (e.g., providing guidance that phone surveys should start with a designated number of call attempts to reach member and end with documentation of engagement).
- **Reviewing and acting on results**: OHIP recommends that SCNs develop plans for collecting, analyzing, and reviewing on a regular basis the results of member experience surveys. For example, SCNs may convene a task force of representatives from the SCN Lead Entity and HRSN service providers on a quarterly basis to review results and develop approaches to action feedback. SCNs should look for trends in the data (e.g., for specific services or provider types, trends by demographic group) and develop action plans as needed based on member feedback.

Member satisfaction is a key component of SCN performance and a priority of the SCN program. SCNs are expected to solicit member feedback on a regular basis and at the end of service delivery and commit to continuous improvement to be responsive to member feedback. SCN Lead Entities will also be responsible for responding to members' complaints, in an effort to improve member satisfaction.

viii. Member Complaints Report

Report description and objectives: The purpose of the Quarterly Member Complaints Report is for SCN Lead Entities to provide an aggregate quantitative summary of member complaints received by the SCN Lead Entity related the SCN program. Complaints may be submitted either directly by a member or by a provider on behalf of a member.

Report metrics and details: The Quarterly Member Complaints Report will include average number of business days between complaint receipt and complaint resolution as well as the number of complaints by type of complaint, by complaint source, and by complaint status (see Member Complaints and Reportable Incidents Section for more details).

Submission details: Reports must be submitted within 1 month after the end of each quarter (e.g., August-October, November-January, February-April, May-July), aligned with the Quarterly Performance Report. Quarterly Member Complaint Reports will be submitted using an Excel template provided by OHIP.

Table 6-9: Quarterly Member Complaint Report

Report sections – subject to change per OHIP

Category	Component
# of member complaints	• # of complaints by complaint status (e.g., received, resolved) • # of complaints by complaint category (e.g., program eligibility, availability of services) • # of complaints by source of complaint (e.g., direct from member, from provider on behalf of member)
Complaint resolution timeline	• Average # of business days to resolve complaint

~~iv.~~ Member Complaints and Reportable Incidents

Complaints may be filed by a member, their parent(s) or legal guardian, provider, or anyone else on behalf of the member regarding the provision of services, activities, or benefits by the SCN program. Submitting a complaint will not jeopardize a member's participation in the SCN program.

Table 6-10: Definitions of grievances, complaints, and reportable incidents

Term	Definition
Grievance	A wrong or hardship suffered (real or perceived), which is the grounds of a complaint
Complaint	Dissatisfaction expressed verbally or in writing by or on behalf of a member. Complaints can include, but are not limited to: • Any violation of rights • Availability of service or ability to receive service • Quality of care received and/or whether services are meeting the member's needs • Afforded choice of HRSN service providers • Program eligibility and/or qualifications • Whether health and welfare are being maintained • Dissatisfaction with services or providers of services
Reportable incident	An event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member

SCN Lead Entity responsibilities: SCN Lead Entities are the first point for review and resolution of incoming member complaints. SCN Lead Entities are expected to review and resolve member complaints in a timely manner. OHIP acknowledges that SCNs will establish varied processes to address member complaints; a minimum set of processes and timeliness standards are outlined below. As the first point of contact for member complaints, SCN Lead Entities should receive all complaints related to SCN operations and service delivery, including but not limited to dissatisfaction with Screening, Navigation, and Enhanced HRSN service delivery (i.e., Care Management, Housing, Nutrition, Transportation), Network capacity and access, and denial of services.

Escalation to MCO or DOH: As appropriate (e.g., the SCN Lead Entity cannot resolve the complaint on their own), SCN Lead Entities may escalate complaints to:

- *Member's MCO*: complaints related to member eligibility for services, or
- *NYSDOH OHIP Bureau of Consumer Services (BCS):* complaints related to plan non-compliance

Complaints submitted directly to MCOs or OHIP: Consistent with existing MCO and OHIP processes, members may also submit complaints directly to the member's MCO or to OHIP.

OHIP may engage relevant SCN Lead Entities regarding member complaints it receives. In the event an MCO receives a member complaint, the member's SCN Lead Entity will be required to provide relevant information to the MCO to address the complaint. MCOs should follow existing MCO approaches and guidelines for SCN program member complaint review, resolution, and reporting to DOH.

In order to help ensure the SCN program addresses the needs of members, OHIP expects SCN Lead Entities to report complaints to OHIP in summary form on a quarterly basis *(See Quarterly Member Complaints Report).*

Member complaint process

Expectations regarding informing members of complaint processes: During the Eligibility Assessment, Social Care Navigators are required to verbally inform members how they may submit complaints to an SCN Lead Entity. SCN Lead Entities should ensure that options for members to submit complaints are varied and accessible and that members may submit complaints at any time.

SCN process to resolve member complaints:
Development of SCN Lead Entity plan for resolving member complaints: OHIP expects that SCNs establish processes related to the review and resolution of complaints. These processes should include at a minimum:

1. Process for how SCNs receive and review complaints
2. Requirements for documenting receipt of a member's complaint (e.g., name, address, phone number of complainant and location, date, and description of the complaint)
3. Guidance for documenting the resolution of member complaints in the member's Social Care Plan (if relevant)
4. Resolution steps that will be taken to address a complaint, including but not limited to:
    - Reviewing the details of the complaint
    - Meeting 1:1 with the member regarding their complaint
    - Sharing the resolution with the member
    - Process to ensure that if a member is not satisfied with the resolution, the SCN must refer the member to their MCO

Termination of Member Services

SCNs must establish policies and processes for termination of member services that are aligned with the following requirements:

As SCNs are engaged in the work of serving vulnerable populations and members with SUD, SMI, SED, I/DD and other behavioral health conditions or members who require differing levels of support accessing HRSN services, SCNs and their network must make efforts to meet members' needs and assist them in obtaining needed HRSN services in furtherance of the program's goals. A member should only be terminated from receiving HRSN

services as a last resort, after de-escalation techniques have been attempted and the consent of OHIP has been obtained.

Documented process for terminating a member:

Protocol for SCN staff and contracted providers to follow when a termination of member services is necessary.

- Termination of services may be considered if an SCN has exhausted all attempts to assist the member. Termination may be appropriate where serving the member would cause an SCN or HRSN service provider's staff member to be in danger or when the member engages in extreme harassment or verbal abuse against SCN staff or any of their contracted partners and de-escalation efforts have been unsuccessful.
- The SCN must alert OHIP of their intention to terminate a member and obtain OHIP's consent prior to finalizing.
- The SCN should provide a full chronological contact log to OHIP documenting all member behaviors which justify termination and all efforts and de-escalation techniques employed by the SCN and its partner in their attempt to serve the member. The log should include, but is not limited to, the following:
    - Dates and times of problematic interactions with the member
    - Written communication from the member
    - Staff and/or contractors present during discussions with the member
    - Details on how the SCN attempted to serve the member including attempts to link the member to known behavioral health providers, MCO care managers, statements from contractors about their interactions with the member
    - General language or behavior the member used against the SCN or contracted entities that led to a termination decision including dates and staff and/or contractor responses.
    - Protocols followed to deescalate harassment or verbal abuse from the member and documentation of the written or verbal warnings provided to the member
    - Entity name and contact information the SCN provided to the Member about existing local, state or federal services that the member can utilize independently while termination is in discussion with OHIP or when finalized

OHIP requirements related to complaints: OHIP wants to ensure that members receive timely resolution for any complaints submitted to SCNs. SCNs must meet the following standards related to complaint resolution:

- **Contacting and updating the member within 72 business hours** of receiving complaint
- **Responding and resolving within 45 calendar days** of receipt of the complaint

SCNs should report to OHIP a summary of member complaints on a quarterly basis. *(See Quarterly Member Complaints Report).*

Member reportable incidents process

In the event a member experiences a reportable incident, SCNs must take additional steps beyond the standard complaints process that account for the member's adverse experience to reach a resolution. SCN Lead Entities should ensure processes are in place such that the Network can meet the following timing requirements with regards to reportable incidents.

- The entity receiving a reportable incident (e.g., Social Care Navigator or HRSN service provider) must inform the SCN Lead Entity of a reportable incident within 24 hours of notification or discovery
- The SCN Lead Entity must inform OHIP of the reportable incident within 24 hours of being informed about the reportable incident via email to SDH@health.ny.gov
    - In sharing the reportable incident with OHIP, SCN Lead Entities should include in the subject line "Reportable incident".

OHIP will review the reportable incident submitted by the SCN Lead Entity and work in collaboration with the SCN Lead Entity to resolve and communicate the resolution to relevant stakeholders, including the member, HRSN service provider, etc.

ix. PMPM Cost Report

Report Description and Objectives: SCN Lead Entities must complete PMPM Cost Reports per the instructions below and submit via the SCN Lead Entity SharePoint site. The objective of the PMPM Cost Report is to record and monitor both the SCN Lead Entities revenues received and expenses to-date.

Report Details: The PMPM Cost Report will be submitted within an OHIP approved Excel template and will include the following tabs for SCN Lead Entities to complete:

1) Revenues received for the SCN Lead Entity includes:

- Total Per Member Per Month (PMPM) funds received by each Lead Entity by MCO
- The 3% administrative funds

2) Expenses for the SCN Lead Entity includes:

- Total amount of PMPM dollars paid out across HRSN services, by HRSN service
- Total amount of HRSN services spend incurred, but not yet paid out to HRSN provider
- Total dollar amounts of encounters submitted to MCOs, by MCO
- Total spend of 3% administrative funds

Submission Details: The initial submission for the PMPM Cost Report was~~is~~ due April 30~~th~~, 2026 and will include data for:

- Program Year 1 (August 1~~st~~, 2024 through July 31~~st~~, 2025) and
- Program Year 2 Quarters 1 and 2 (August 1~~st~~, 2025 through January 31~~st~~, 2026)

Thereafter, PMPM Cost Report submissions will be 1 month after end for each quarter (February-April, May-July, August-October, November-January).

- May 31~~st~~, 2026 (reporting data for PY2 Q3: February 2026-April 2026)
- August 31~~st~~, 2026 (reporting data for PY2 Q4: May 2026-July 2026)
- November 31~~st~~, 2026 (reporting data for PY3 Q1: August 2026-October 2026)
- February 28~~th~~, 2027 (reporting data for PY3 Q2: November 2026-January 2027)
- April 31~~st~~, 2027 (reporting data for PY3 Q3: February 2027-March 2027)

7. PAYMENTS

Payments sub-sections:

a. Infrastructure Funding

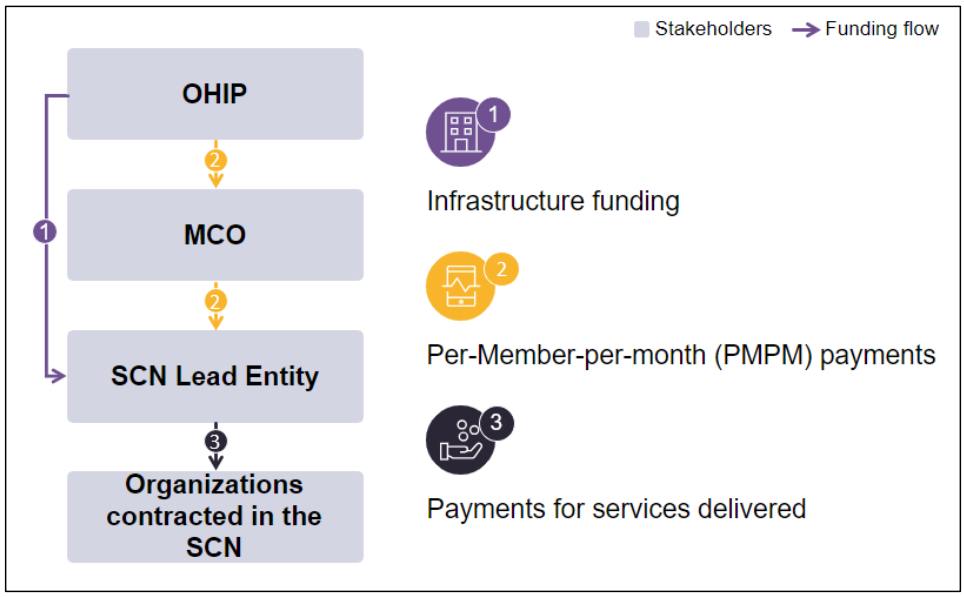
b. PMPM Payments

c. Payment Methodology for Services Delivered

SCNs will be funded under the 1115 Waiver until March 31, 2027. The SCNs will have three main funding sources throughout the three-year contract:

1. *Infrastructure funding:* Funding to SCNs for operational setup of the program. SCNs will use infrastructure funding to build necessary functionality of the Network.
2. *PMPM payments:* Payments for Screening, Navigation, and Enhanced HRSN Services will flow from OHIP to the MCOs and from MCOs to SCN Lead Entities. The MCO will make PMPM payments to the SCN by the 15th of each month.
3. *FFS payments for Screening and HRSN services:* SCN Lead Entities will pay for Screening, Navigation, and Enhanced HRSN Services delivered according to a set HRSN fee schedule.

Figure 7-1: Overview of payment flows included in SCN program



For the Medicaid FFS population, the SCN Lead Entity will directly bill eMedNY for Screening and Navigation for the region's Medicaid FFS population. The SCN Lead Entity will use the PMPM Payment to provide the Network with payments for Screening, Navigation, and Enhanced HRSN Services for the Medicaid Managed Care population.

After the 1115 Waiver period, a subsequent payment mechanism may be established and is beyond the scope of the current program. SCNs may continue to receive funding from state, federal, or private grants during and after the initial three-year contract period.

The following section provides an overview of each type of payment within the 1115 Waiver, including funding amount and mechanics details, uses of funding, and funding requirements.

a. INFRASTRUCTURE FUNDING

i. Funding amount and mechanics

To ensure that SCNs are able to build capacity and capabilities, OHIP is providing up to $500 million in federal infrastructure funding for the operational setup of the program across the three-year RFA period. SCN Lead Entities may use infrastructure funding to build necessary functionality and capabilities across the Network, either through direct use of funds for activities impacting capabilities of the Network, or via capacity building grants provided to CBOs.

The maximum infrastructure funding available for each SCN varies by region and is based on the number of Medicaid members and cost of delivering HRSN services in its region. OHIP has communicated to each SCN Lead Entity the maximum funding amount available in each year. SCN Lead Entities are required to keep receipts, records, and other financial documents related to the federal infrastructure funding for the balance of each calendar year in which they were made and for six (6) additional years thereafter.

While OHIP's goal is to ensure that all SCNs receive the maximum amount of infrastructure funding, SCNs will be expected to provide reports and achieve certain operational and performance milestones in order to receive their maximum amount of infrastructure funding. These contingencies are intended to incentivize SCNs to prioritize critical operational and performance goals, as well as prepare SCNs for more robust value-based payment models in the future. Payment will be contingent on three types of requirements:

1. Submitting required reports
2. Completing key implementation milestones
3. Achieving performance targets

OHIP will issue a 25% advance of Year 1 infrastructure funding immediately after SCNs execute their contracts with OHIP, and funding will be paid on a quarterly basis thereafter. The 25% advance funding is subject to recoupment every quarter.

SCN Lead Entities will receive the majority of their infrastructure funding beyond the advance retrospectively after the milestones and targets are reached and reports are submitted.

ii. Uses of funding

SCNs will use infrastructure funding to build necessary functionality across the Network, including but not limited to initial Network infrastructure set-up (e.g., onboarding of CBOs), initial set-up and implementation of the SCN IT Platform, hiring and recruiting of staff, CBO capacity building activities and technical assistance, contracting, and community and health care provider engagement. Infrastructure funds cannot be used for EHR interoperability integration (e.g., API to connect EHR to SCN IT platform).

SCNs may rollover unspent funds from quarter to quarter, subject to the spending minimum detailed below.

OHIP will collect the SCN Lead Entities' estimated infrastructure budget proposal for each year based on the Annual Infrastructure Reassessment Report and will require SCN Lead Entities to report their expenditures on a quarterly basis.

Table 7-1: Allowable uses of infrastructure funding and eligible organizations

Infrastructure funding category	Use of funds	Mechanism for SCN Lead Entity or other entity to use funds
SCN Lead Entity core staff costs	• Cover salaries for key SCN staff members working directly on the program (e.g., program director, Social Care Navigators)	• Funding used directly by SCN Lead Entities • SCN Lead Entities may use funding to hire Social Care Navigators at other entities in the Network
SCN Lead Entity administrative / indirect costs	• Cover indirect operating expenses (e.g., back-office staff, physical office space, legal fees, etc.)	• Funding used directly by SCN Lead Entities
IT Platform and Systems costs	• Support entities contracted into the SCN to onboard onto the SCN IT Platform (e.g., vendor or user licenses) • Build technical capabilities of entities contracted into the Network (e.g., additional training not provided by IT vendors)	• SCN Lead Entities may use funds to support any organization contracted in the Network, including CBOs, FQHCs, Health Systems, Health Homes, Care Management agencies, etc.
Capacity building funding for CBOs	• Build capabilities (e.g., hiring staff members) and program functionality (e.g., provide training for staff, purchase equipment, rent office space) of CBOs contracted into the Network to deliver Enhanced HRSN Services	• SCN Lead Entities provide funding to CBOs (*see Expectations for capacity building section 4.a.viii for details on what entities may receive capacity building funding*)

iii. Funding requirements

Each quarterly payment will be split into portions tied to reporting requirements, implementation milestone requirements, and performance requirements. If an SCN fails to meet any of these requirements in a given quarter, it will not receive the funding tied to that requirement for that quarter. The funding amounts tied to each requirement type in each quarter are shown in Table 7-2.

Table 7-2: Breakdown of infrastructure funding amounts tied to reporting, implementation milestones, and performance

Type of requirement	Performance/Contract Year 1 (8/1/2024 – 7/31/2025)	Performance/Contract Year 2 (8/1/2025 – 7/31/2026)	Performance/Contract Year 3 (8/1/2026 – 3/31/2027)
Reporting	90% of infrastructure funding	85% of infrastructure funding between 8/1/2025 - 4/30/2026 80% of infrastructure funding between 5/1/2026 - 7/31/2026	80% of infrastructure funding
Implementation milestones	10% of infrastructure funding	5% of infrastructure funding	5% of infrastructure funding
Performance	N/A	10% of infrastructure funding between 8/1/2025 - 4/30/2026 15% of infrastructure funding between 5/1/2026 - 7/31/2026	15% of infrastructure funding

Refer to quarterly infrastructure milestone and performance metric guidance for up-to-date payment details.

Beyond these requirements, SCN Lead Entities will be required to spend a portion of infrastructure funds previously received in order to receive additional funds in the next quarter.

~~**Spending minimum:** SCNs will be required to spend a minimum amount of infrastructure funding to be eligible for additional funding in Year 2 Quarter 1 and Year 3 Quarter 1. This is to ensure that SCNs are building critical infrastructure and capacity quickly in order to accomplish program objectives. To be eligible to receive a quarter's infrastructure funding (following the end of a quarter), SCNs must have cumulatively spent 70% of the total funding received to date for all but the most recent quarter, in Performance Year 2 Quarter 1 and Year 3 Quarter 1. If an SCN Lead Entity does not reach the 70% threshold in the new year's first quarter, the SCN Lead Entity may only receive additional funds in a subsequent quarter (after the 70% threshold is met). For example, an SCN will be eligible to receive payment for Q1 of Year 2 if the following calculation reaches at least 70%:~~

- ~~Numerator: all funds spent to date up to reported spend in PY2 Q1 (source: Infra Cost Report – PY2 Q1)~~
- ~~Denominator: all funds received up to and including payment for PY1 Q3 (source: BSCCS / OHIP fiscal)~~

Reporting requirements: SCNs are required to submit reports in each quarter as outlined in the Reporting section. Because these reports are critical for SCN operations and OHIP's ability to monitor and evaluate the program, the vast majority of infrastructure funding will be contingent on reporting. SCN Lead Entities will need to submit timely, accurate, and complete reports in order to receive payments.

OHIP expects all SCNs to satisfy reporting requirements every quarter to receive the associated funding. SCNs cannot earn partial payment of funds tied to reporting by submitting some required reports but not others.

Implementation milestone requirements: SCNs are required to complete a series of implementation milestones to ensure their readiness to perform core program responsibilities and deliver high quality services. The percentage of infrastructure funding tied to milestone implementation is higher in Performance Year 1 (10%)

than Performance Years 2 and 3 (5%) because the implementation milestones due in Year 1 are essential for SCN operations in subsequent years.

To receive infrastructure payments linked to implementation milestones in a given quarter, SCNs must complete all the milestones due in that quarter by the end of the quarter. SCNs will attest to NYS that they have completed a milestone, and NYS may choose to audit SCNs to ensure satisfactory completion of the milestone. SCNs cannot earn partial payment of funds tied to implementation milestones by completing some required milestones but not others. The specific implementation milestones will be communicated by NYS to SCN Lead Entities directly on a quarterly basis for each performance year.

Performance requirements: A limited portion of infrastructure funding will be tied to SCN performance in order to prepare SCNs for more robust value-based payment programs in the future. Infrastructure funding is not tied to performance metrics in Performance Year 1 because SCNs have varying degrees of experience delivering HRSN services. Moreover, OHIP plans to use baseline performance data collected in Performance Year 1 to determine the appropriate performance targets to set for each SCN in subsequent years. In Performance Year 2, 10% of infrastructure funding will be tied to performance metrics between 8/1/2025-4/30/2026 and 15% of infrastructure funding will be tied to performance metrics between 5/1/2026-7/31/2026. In Performance Year 3, 15% of infrastructure funding will be tied to performance metrics. ~~and 15% in Performance Year 3.~~ Refer to quarterly infrastructure milestone and performance metric guidance for up-to-date payment details.

OHIP has selected a subset of the performance metrics described in the Performance Management section that will be tied to infrastructure payments in Performance Year 2 and Year 3. These metrics capture operational effectiveness across the member journey and within the control of the SCN.

Payment will be tied to SCN performance metrics, such as:

- Members screened (#, %)
- Members assessed (#, %)
- Members with identified unmet HRSNs who are successfully contacted within 5 business days (%)
- Members referred within 7 business days (%)
- Referrals made that are accepted within 5 business days (%) (Year 3 only)
- Closed Loop Referral rate (% of referrals)

After collecting baseline performance data, NYS will communicate additional details on the specific targets SCNs will need to meet for each metric in each quarter. To receive infrastructure payments tied to performance in a given quarter, SCNs must achieve all the performance targets set for that quarter. OHIP will not make partial payment to SCNs that achieve some performance targets but not others. Refer to quarterly infrastructure milestone and performance metric guidance for up-to-date payment details

b. PMPM PAYMENTS

(January 1, 2025 – March 31, 2027)

i. Funding amount and mechanics

OHIP has developed PMPM rates for MCOs to provide to SCN Lead Entities using 1115 Waiver dollars that are separate from infrastructure funding. OHIP will provide PMPM payments to MCOs for all attributed Medicaid members (including unengaged) within the SCN Lead Entity's region.

The PMPM payments provided by MCOs to SCNs will account for the regional cost to conduct HRSN Screening and Navigation and deliver Enhanced HRSN Services. PMPM amounts will be informed by the weighted average of Navigation and Enhanced HRSN Services for all MMC members (excluding FFS).

PMPM administration process: PMPM payments will be administered monthly from MCOs to SCNs according to the following process:

- OHIP will provide regional 1115 Waiver funding directly to MCOs for the purpose of distributing PMPM payments to the SCN Lead Entities (MCOs will bill eMedNY for the PMPM on a monthly basis)
- The MCO will then allocate a PMPM payment to each regional SCN Lead Entity by the 15th of every month
- SCN Lead Entities will provide social care claims to all contracted MCOs for HRSN Services provided to members within the Network
- The service amount submitted on the social care claim will be based on each SCN's HRSN fee schedule approved by OHIP
- The claim will include the HRSN price, associated rate codes, HCPCS codes and applicable modifiers for the SCN Lead Entities

PMPM reconciliation process: OHIP will reconcile PMPM payments received against actual HRSN spending via encounters submitted for screening and service delivery. The reconciliation process will assess whether MCOs and SCNs received accurate PMPM payment consistent with Medicaid Managed Care enrollment and NYHER waiver eligibility; and whether spending on HRSN services were consistent with established HRSN fee schedule. PMPM payments will be reconciled on an annual basis as follows:

- *Reconciliation inputs:* Reported Encounter data submitted by the MCOs to OHIP will serve as the definitive source of fees paid for services rendered
- *Timing:* Annual PMPM reconciliations will begin six months after the close of the OHIP fiscal year on March 31 (which is the service cut-off date), with the first reconciliation commencing after September 30, 2025 (which is the cut-off date for encounter submission)
- *Process:*
    - OHIP will share reconciliation results with the MCO and the SCN
    - Within 30 days, the MCO and SCN must provide sign off or provide feedback on the reconciliation results. In the event that the MCO or SCN contests the results, the MCO, SCN, and OHIP will commence the documentation review process to complete the reconciliation
    - OHIP will be responsible for determining final reconciliation amounts. The MCO will be responsible for either distributing additional funds or collecting the actual recoupment amount and will create an agreed upon process for reconciliation with the SCN Lead Entity
- *Outcomes of reconciliation process:*
    - *OHIP Overpayment to SCN via MCO:* If the results of the reconciliation process based on Medicaid member enrollment, NYHER waiver eligibility, and encounter data indicates that

aggregate PMPM payments net of the fees for services rendered is greater than the allowable PMPM, the excess payment will be recouped from SCN Lead Entities via the MCOs

OHIP Underpayment to SCN via MCO: If the results of the reconciliation process based on Medicaid member enrollment, NYHER waiver eligibility, and encounter data indicates that aggregate PMPM payments net of the fees for services rendered is less than the allowable PMPM, the additional true-up payment will be provided to the SCN Lead Entities via the MCOs. For details on the reconciliation process, see the Reconciliation Guidance Memo issued on 9/13/2025.

ii. Uses of funding

PMPM payments will primarily be used for the SCNs to reimburse contracted SCN organizations based on the HRSN fee schedule for Screening, Navigation, and Enhanced HRSN Service Delivery for MMC members.

SCN Lead Entities are expected to reimburse contracted organizations in their Network for all approved services delivered, including for one annual HRSN Screening per member (unless a member is eligible for a Re-Screening due to a major life event).

SCN Lead Entities may use a maximum of 3% of PMPM funds they receive for ongoing administrative and operational costs incurred for HRSN service delivery (e.g., claims processing, performance management). The remaining 97% of PMPM funds sent to SCN Lead Entities may be used to cover service delivery (e.g., Screening, Navigation, delivery of Enhanced HRSN services) or to accrue for annual reconciliation.

The administrative 3% is not subject to recoupment except when it has been paid as the result of an inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. The administrative 3% will not be recouped as part of the reconciliation process due to member's HRSN service utilization or eligibility for Enhanced HRSN services.

iii. Funding requirements

OHIP will require SCNs to report use of PMPM payments on a quarterly basis as outlined in the Reporting Section. This includes the detailed tracking of Social Care Claims, which will be used to provide a record of the Medicaid Managed Care member's rendered encounter (e.g., Screening, Medically Tailored Meal, etc.) with a contracted HRSN service provider in the SCN.

SCN Lead Entities will send the Social Care Claims to MCOs through the SCN IT Platform. The MCO will keep these claims for recordkeeping and use the claims to submit the encounter data to the State, which will be used for program analysis and annual funding reconciliation.

The FFS population will be billed separately by the SCN Lead Entity through eMedNY and will not be included in the Social Care Claims process. SCN Lead Entities should follow the procedures listed within the eMedNY website, www.eMedNY.org for FFS billing.

Data elements for Social Care Claims: Please refer to the most recent Data and Systems Implementation Guide (DSIG) for specific information regarding data elements for social care claims.

The SCN Lead Entity is expected to automate the process for submitting Social Care Claims to MCOs. Social Care Claims for Enhanced HRSN Services must be sent to MCOs via Electronic Data Interchange (EDI) 837 file format. The SCN Lead Entity must submit all claims to MCOs via the SCN IT Platform within 90 days from payment date.

Tracking and receiving Social Care Claims:

- After the HRSN service provider has indicated in the SCN IT Platform that a service has been completed, the SCN Lead Entity will submit the Social Care Claim to the MCO through the SCN IT Platform in the EDI 837 file format
- The MCO will accept and intake accurate claims and send back to the SCN Lead Entity an 835 remittance
- SCN Social Care Claims for Enhanced HRSN Services will be linked to MCO claims and reported Encounter data to support the tracking of outcomes
- After the service is delivered, the MCO must collect and retain claims submitted by the SCN for a minimum of ten years per federal requirements

c. PAYMENT METHODOLOGY FOR SERVICES DELIVERED

(January 1, 2025 - March 31, 2027)

i. Funding amount and mechanics

The SCN Lead Entity is responsible for paying organizations contracted in the SCN for Screening, Navigation, and Enhanced HRSN Services based on each SCN's HRSN fee schedule approved by OHIP.

The HRSN fee schedule includes guidance on how services should be delivered to receive reimbursement, and where relevant, maximum allowable units and frequency for specific services. Rate types vary by service, and include:

- Rates: Specific rate for the delivery of a service
- Ranges: A rate range (high/low end) that will give SCNs flexibility to set rates for different scopes of services delivered. For services for which OHIP has provided a range, SCNs are expected to manage expenditures by setting rates based on individual member needs (i.e., services should fall into the upper portion of the range only in limited circumstances)
- Per member cap: A maximum amount that can be spent on a particular service category that provides SCNs with flexibility on the best way to address a member's needs as it relates to that service

In the context of the 1115 Waiver, CMS has established annual program-level caps for funding for MMC members across three HRSN service categories: CTS Broker's Fee, Cooking Supplies, and Transportation Services. For each of these three Enhanced HRSN Services with caps, OHIP will define SCN-level annual caps that take into account member needs in each region. OHIP has defined SCN-level caps for the duration of the waiver (January 1, 2025-March 31, 2027). ~~for Year 1 (January 1, 2025 - March 30, 2026) based on the Enhanced Population in each SCN region and costs to deliver services in each region (for transportation). OHIP will determine new SCN-level caps for Year 2 and may base new caps on demand for services across each region as information becomes available during the program.~~

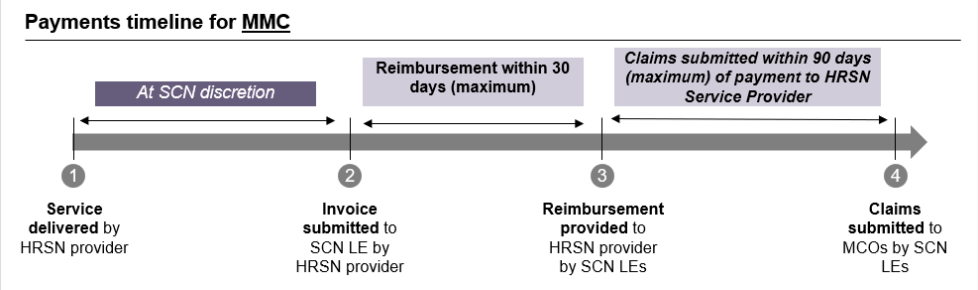
Each SCN Lead Entity is responsible for managing spend for their region and ensuring services do not exceed the defined cap, as provided in each SCN's HRSN fee schedule.

ii. Uses of funding

SCN Lead Entities are responsible for payment of services for two different types of members:

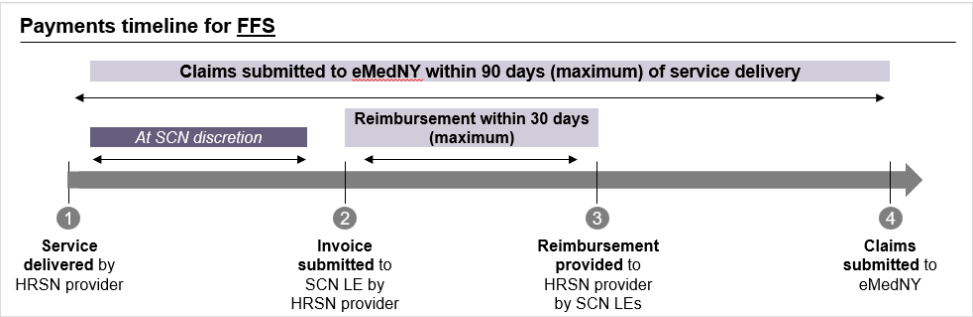
1) *Medicaid Managed Care members (PMPM payments)*
    - Payments will flow from the SCN Lead Entity to HRSN Service providers based on the HRSN fee schedule approved by OHIP. SCN Lead Entities must be designated as official Medicaid billing social care provider entities and must process claims and payment on behalf of the contracted organizations in their network for delivering Screening, Navigation, and Enhanced HRSN Services
    - Contracted HRSN service providers must submit accurate invoices for rendered services no later than five **(5)** business days from the date of service delivery.
    - The SCN Lead Entity will provide HRSN fee schedule-based reimbursement payments to contracted HRSN service providers within thirty (**30)** days after an accurate invoice for service delivery is generated in the SCN IT Platform. For Home Remediation Service, reimbursement should be provided by the date specified in the contracted provider's invoice. The SCN Lead Entity must submit all claims to the MCOs ~~within ninety (**90**)~~no later than ten **(10)** business days from payment date
    - Payments to the HRSN service providers should be made on at least a monthly basis for services provided on an ongoing, regular cadence that span over multiple months
    - Program-level funding caps for select Enhanced HRSN Services (e.g., CTS Broker's Fee, Cooking Supplies, and Transportation services) previously described will apply for each SCN. SCN Lead Entities are responsible for managing these caps
    - ~~The SCN Lead Entity must submit all claims to MCOs via the SCN IT Platform within ninety (**90**) days from payment date~~
    - The date of service on the claim from SCN Lead Entity to the MCO cannot be for a future date and must reflect a date after the date of service has passed regardless of how internal invoicing is conducted (e.g., advance payments for rent, bulk claims from HRSN service providers for on-going services)
    - If the Member has the same service, on the same day, with the **same rendering provider**, then the services will need to be consolidated into a single claim. To achieve this, total units and payments provided must be rolled up together. Without doing so, the claims will be identified as duplicates and will be rejected by the State encounter system (OSDS) and may additionally be rejected by MCOs.

Figure 7-2: Payments Timeline for MMC Members



2) *Medicaid FFS population (eMedNY FFS Billing)*
   - OHIP will reimburse the SCN Lead Entity for the Medicaid FFS population upon a submitted claim
   - Each regional SCN Lead Entity will have direct access to bill eMedNY for Screening and Navigation associated to the region's Medicaid FFS population
   - SCN Lead Entities should bill eMedNY directly for services completed within the Medicaid FFS population for Screening and Navigation based on the regional HRSN fee schedule, billing, and service codes provided by OHIP
   - The SCN Lead Entity in turn, will submit the rendered Medicaid FFS claim through eMedNY with their corresponding MMIS# and NPI number, HRSN service data such as the ICD-10 diagnosis code, HCPCS procedure and modifier codes, and if applicable, the CBO's EIN, TIN, or NPI
   - OHIP will monitor Medicaid FFS claims within eMedNY as needed. The SCN is not required to submit a report to support eMedNY claims
   - The SCN Lead Entity must submit claims to eMedNY within ninety (**90**) days of service delivery date

Figure 7-3: Payments Timeline for FFS Members



iii. Funding requirements

SCN Lead Entity provider designation is necessary to reimburse for services. The SCN Lead Entity is expected to obtain designation in eMedNY as a new category of Social Care Network Medicaid Social Care Provider and will receive a MMIS# for billing.

See SCN Provider Designation and Enrollment for more details.

The combination of an MMIS# and NPI number will allow the SCN Lead Entities to receive PMPM from MCOs and pay contracted HRSN Service Providers for services. The professional designation allows the SCN Lead Entity to bill eMedNY for Medicaid FFS services (Screening and Navigation).

iv. Reimbursement for services delivered by HRSN service providers in the SCN

Reimbursement for services delivered as part of SCN program: HRSN service providers within the SCN may be receiving funding from other sources to provide HRSN services to Medicaid members (e.g., via block grants). For all individuals that meet the below criteria, HRSN service providers may bill and be reimbursed for services delivered in accordance with the regional fee schedule established by the SCN Lead Entity.

HRSN service providers may be paid for Screening and services delivered if…

- They are contracted with the SCN Lead Entity
- They remain in Medicaid *Good Standing* (if applicable)
- Member was screened using the SCN IT Platform or a unique Screening IT platform as approved by the SCN Lead Entity in contract or sent by a provider through SHIN-NY or a Qualified Entity
- For Enhanced HRSN Services, member was referred to the Enhanced HRSN service provider through the SCN referral pathway (e.g., by a Social Care Navigator who conducts an Eligibility Assessment using the SCN IT Platform or another platform able to send referral information to the SCN IT Platform)
- Member is eligible for the HRSN service as determined by the SCN program; for Enhanced HRSN Services, eligibility requires members to be enrolled in Medicaid Managed Care, meet specific Enhanced Population and clinical criteria, and demonstrate unmet health-related social needs determined by the SCN program
- The Medicaid member is not already receiving a duplicative Enhanced HRSN Service from an alternate source (e.g., through federal, state, or local funding sources), as determined by the Social Care Navigator
- Enhanced HRSN Services delivered are among the services approved by the SCN program *(see https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm)*
- HRSN service provider follows any additional agreed upon terms as outlined in contracts with SCN Lead Entities

Regardless of whether HRSN service providers receive additional funding to provide services to Medicaid members, HRSN service providers may bill and be reimbursed via NYHER for all members and services that meet the above criteria.

HRSN service providers must ensure that the funds administered are for the purpose of supplementing existing activities and never used to supplant funds for activities that were previously covered by other federal, state, or

local funding. NYHER reimbursement for HRSN service delivery is not considered duplicative if the service provided to the individual meets the criteria above. HRSN service providers with multiple funding streams should ensure they follow the requirements of each source of funding (e.g., reporting requirements).

Using multiple funding sources to provide services to a member: The 1115 waiver funding for HRSN services may not replace funding from other local, state, or federal programs. When applicable, this funding should be used to support the allowable HRSN services that the member cannot access through other programs. New York State encourages HRSN service providers to use multiple funding sources to holistically address member needs. Braided funding consists of multiple funding sources that are initially separate, brought together by an organization to pay for more than one funding source can support, and then carefully pulled back apart to report to funders on how the money was spent. For example, a Medicaid member can receive housing navigation under a grant program and then be referred to the SCN to receive Community Transitional Supports paid through the waiver.

Services provided to a member that are outside the scope of the NYHER waiver amendment cannot be reimbursed regardless of whether a member is concurrently receiving SCN-referred services. Government entities (e.g., local departments of social services or local health departments) may not be reimbursed through SCN program funds for any SCN services, including Screening, Navigation, or Enhanced HRSN Service delivery.

8. CONTRACT REQUIREMENTS

Contract requirements sub-sections:

a. Introduction to SCN Contract Requirements

b. SCN Medicaid Billing Social Care Provider Designation and Enrollment

c. SCN Contract Requirements with OHIP

d. SCN Contract Requirements with MCOs

e. MCO Contract Requirements with OHIP

f. SCN Contract Requirements with HRSN Service Providers and Other Entities

a. INTRODUCTION TO SCN CONTRACT REQUIREMENTS

Each organization serving as an SCN Lead Entity will contract with:

1. New York State directly (which will require designation as a Medicaid billing social care provider)
2. All MCOs in their region
3. Entities providing Screening, Navigation, or Enhanced HRSN Service Delivery to members in their region (including but not limited to HRSN service providers as well as health care providers).

It is expected that SCNs establish contracts with organizations in their Network such that the SCN can begin delivery of HRSN services, including Screening, Navigation, and Enhanced HRSN Services by January 1, 2025.

Specific expectations with regards to SCN contracts are outlined below.

b. SCN MEDICAID BILLING SOCIAL CARE PROVIDER DESIGNATION AND ENROLLMENT

OHIP expects that SCN Lead Entities will go through the full enrollment and determination process to become a New York State-designated Medicaid billing social care provider. The Medicaid billing social care provider designation will enable SCN Lead Entities to contract with MCOs to facilitate payment for the provision of Screening, Navigation, and Enhanced HRSN Services for Medicaid Managed Care members. Additionally, SCN Lead Entities will be able to bill via eMedNY directly for HRSN Screening and Navigation of Medicaid FFS members.

Only the awarded entity will become a designated SCN Lead Entity. However, SCN Lead Entities are permitted to subcontract with vendors for revenue cycle management and other billing-related support. SCN Lead Entities must provide the subcontracted entity with the appropriate credentials to utilize for MCOs and eMedNY.

i. Designation process

Following awards, SCN Lead Entities must initiate an application in eMedNY to become a Medicaid billing social care services provider and obtain an MMIS# in accordance with established protocol. The designation process will allow SCN Lead Entities to utilize the OHIP-prescribed agreements with MCOs to receive PMPM payments for use of issuing payments to the Network for Screening, Navigation, and Enhanced HRSN Services. The designation will also permit the SCN Lead Entity to bill eMedNY directly using an official MMIS# for FFS Medicaid member's Screening and Navigation.

Table 8-1: Expected process for SCN Lead Entity provider designation

Step	Details	Timing
1	Apply for an NPI at NPPES (hhs.gov)	Within 15 days of award date The NPI is generally issued within 5 days of request
2	Once the applicant has received the new NPI number, complete the eMedNY designation process and fill out the SCN provider application at Provider Enrollment (emedny.org)	Within 15 days of award date
3	Await review and approval for designation and MMIS#	
4	Upon successful enrollment in eMedNY, SCN Lead Entities may bill for the provision of Screening and Navigation for the Medicaid FFS population	By January 1, 2025
5	Every five years from contract execution, SCN Lead Entity is required to redesignate in eMedNY	Every 5 years following initial designation

Designation Step 1 details: Obtaining a National Provider Identifier (NPI)

Before enrolling in eMedNY, SCN Lead Entities need to register for an NPI. The NPI is a unique 10-digit identification number issued to health care providers in the U.S. by CMS.

- A new NPI is required even if the SCN Lead Entity currently has an NPI number that has already been used for another Medicaid Category of Service (COS)
- The application for an NPI number can be found on the National Plan and Provider Enumeration System (NPPES) website: https://nppes.cms.hhs.gov/#/
- The NPI number is generally issued within **5 days** and is required to complete an eMedNY application Provider ID (next step)

For questions regarding the NPI application process, refer to RFA award letter for direct contact liaison email address.

Designation Step 2 details: SCN enrollment (eMedNY) application

The eMedNY designation process enables SCN Lead Entities to become Medicaid billing social care providers. Specific designation of "Professional" in eMedNY will permit the applicant to bill MCOs for Medicaid Managed Care services and submit claims to eMedNY for the Medicaid FFS population.

Once SCN Lead Entities have received NPI numbers, they will complete the designation process through https://www.emedny.org/. The RFA Conditional Award letter will serve as the authorization to proceed with the eMedNY designation and will need to be uploaded. Upon approval, eMedNY will provide the SCN Lead Entity with an official MMIS# for billing eMedNY.

For questions regarding the eMedNY application process contact the eMedNY Call Center: 1-800-343-9000.

Designation Step 5 details: Redesignation

SCN Lead Entities will be required to go through a redesignation process every **5 years** to maintain their ability to be a Medicaid billing social care provider. In determining continued designation, OHIP may examine performance reports and their associated metrics.

Failure to become designated

If the applicant fails to properly enroll in eMedNY within **15 days** of the dated award letter or is otherwise denied successful enrollment per eMedNY administrators, OHIP will ensure the applicant's contract and conditional award is relinquished. The applicant will forfeit any agreement made with OHIP under the RFA.

If the applicant is denied during the eMedNY Provider Enrollment process, the award will be rescinded and will go to the next applicant with the highest score in the region. If there are no further fundable awards in the region, OHIP reserves the right to award what is in the best interest of OHIP or re-solicit that region.

c. SCN CONTRACT REQUIREMENTS WITH OHIP

i. SCN Responsibilities

SCN Lead Entities designated as Medicaid billing social care providers will maintain a separate contract with OHIP for each region for which they are responsible.

ii. SCN IT Platform Requirements

Ensuring that the required capabilities of the SCN IT Platform are in place is a critical requirement of the SCN contract with OHIP.

The SCN Lead Entity will ensure their systems have near real-time bi-directional data exchange capability through a Service Level Agreement (SLA) with their platform vendor. Contracted data and IT technology companies are not considered to be part of the SCN.

(*For information on SCN IT Platform requirements, see IT Platform Requirements. For more information on 1115 SHIN-NY Interoperability Guidance for SCN Lead Entities and their IT Platform partners, visit the NYeC Website 1115 Waiver support website*).

iii. SCN Conflict of Interest Plan

To ensure that SCNs operate in the member's best interests, each SCN Lead Entity should establish COI considerations for their Network. Each SCN Lead Entity is required to create a COI Plan, detailing how their Network will maintain COI for the duration of the SCN Program. Each SCN's COI Plan was due to OHIP on November 30, 2024, for OHIP review and approval. SCN Lead Entities are responsible for avoiding conflicts of interest, including conducting trainings for Social Care Navigators on provision of freedom of choice to members, monitoring prevalence of internal referrals by SCN Lead Entities and HRSN service providers, and making efforts to expand networks to reduce the need for internal referrals.

OHIP requires the following components of the COI plan to be included in each SCN Lead Entity's Plan:

1. **Ensure Social Care Navigators are not related to the member**, their paid caregivers, or anyone financially responsible for the member. "Relative" shall mean the individual's (i) spouse, ancestors, brothers and sisters (whether whole or half-blood), children (whether natural or adopted), grandchildren, great-grandchildren, and spouses of brothers, sisters, children, grandchildren, and great-grandchildren; or (ii) domestic partner as defined in Section 2994-a of the New York Public Health Law or any successor statute
2. **Ensure Social Care Navigators follow the gift prohibition,** contracted HRSN service providers may not provide any gift or entertainment to a Screener or Social Care Navigator, and no Screener or Social Care Navigator may accept any gift or entertainment from a contracted HRSN service provider
3. **Ensure program eligibility determination and Navigation are separated from Enhanced HRSN Service delivery,** including:
    - **What safeguards and firewalls will be in place to mitigate risk** of potential conflict in circumstances where one entity is responsible for both Navigation and Enhanced HRSN Service delivery
    - **What safeguards will be in place to ensure that technical review of SOWs is independent of Enhanced HRSN Service delivery** for Home Accessibility and Safety Modifications, Home Remediation, and Asthma Remediation
    - **How the SCN LE and their contracted network will disclose their dual relationship to members** in the event one entity is responsible for both Navigation and Enhanced HRSN Service delivery
        - In the event that an SCN Lead Entity or their contracted network navigates and is also an HRSN service provider, members should be verbally informed of the SCN Lead Entities or their contracted network's dual relationship of Social Care Navigator/HRSN service provider and also provide a statement to the member about freedom of choice during the Eligibility Assessment and before consent for referral. Verbal statements should convey that members do not have to use the SCN Lead Entity or HRSN service provider with dual relationship of Social Care Navigator/provider and when applicable and available the members are provided options and member preference must be considered first. Social Care Navigators should document in the Social Care Plan that freedom of choice was verbally provided to the member during the Eligibility Assessment for the Enhanced Population
4. **Monitor and oversee potential COI**

- Monitor the prevalence of internal referrals. If an SCN notices that one of their contracted HRSN providers is habitually making internal referrals, SCN will be expected to discuss live during 1:1 why this is occurring and what good faith efforts are being made to expand their network so that the provider does not have to make as many internal referrals. Likewise, if the SCN itself engages in Navigation and the provision of HRSN services, and it habitually makes internal referrals, SCN must make reasonable efforts to expand its network to reduce the need for continued internal referrals
- Monitor the prevalence of referrals between organizations with relationships beyond the SCN program

5. **Enforce the COI plan** across the Network. SCNs must document training was provided within the Quarterly Performance Report
6. **Re-evaluate safeguards** and firewalls at least on a biannual basis

iv. Contract Termination

SCN Lead Entities will be required to follow all requirements as outlined under the OHIP-SCN contract and within this Operations Manual. After the contract with OHIP is executed, SCN Lead Entities will be responsible for all deliverables and requirements outlined in the contract and within this Operations Manual. Failure to meet milestones and objectives may result in contract termination with OHIP and loss of designation as an SCN Lead Entity.

d. SCN CONTRACT REQUIREMENTS WITH MCOs

i. Overview of contracting expectations

SCN Lead Entities will be required to contract with every MCO with Medicaid members in their region, establishing that it is serving as part of the Medicaid care delivery team. MCOs cannot opt out of contracting with SCN Lead Entities. OHIP has provided a template for agreements between SCN Lead Entities and MCOs that OHIP strongly encourages parties to use for contracting.

(*For more information on specific contractual requirements, see the MCO-SCN Agreement Template Attachment*). See below for additional details regarding MCO responsibilities.

ii. Eligible Lines of Business

The MCO PMPM rate amounts provided to the SCN Lead Entities include certain Eligible Lines of Business. Any HRSN services already covered by an eligible line of business is excluded from participating in the SCN's Enhanced HRSN Services.

iii. Enhanced Services Member File

An Enhanced Services Member File, which includes all MMC plan members, will be referenced during the Eligibility Assessment to identify all members who reside in the SCN's region and detail their eligibility information. (*For more information, see Enhanced Services Member File)*

iv. PMPM Payments

The purpose of the PMPM payment methodology is to ready the MCOs and SCNs to participate in VBP arrangements after year 3 of the demonstration period. After year 3, when VBP arrangements begin, the payment structure will remain, assumption of risk will begin, and the methodology will be embedded into the Managed Care Model Contract.

(*For additional information on PMPM policies / procedures, see MCO-SCN Agreement Template and Operations Manual Payments section*).

v. MCO SCN IT Platform Training

The SCN Lead Entity must onboard, train, and support MCOs who elect to use the SCN's IT.

- SCN Lead Entity must provide guidance to MCOs to conduct Social Care Navigator responsibilities, including conducting Screening, Eligibility Assessment, and Navigation including referrals (the MCO will not be reimbursed for these activities)
- MCOs must be able to retrieve down previous Screenings from SHIN-NY to check for duplication of Screening efforts

vi. Ongoing Data Requests

MCOs must work in conjunction with the SCN Lead Entity to submit timely data to OHIP or CMS as needed and as requested. Examples of MCO data requests may include but are not limited to:

- Data to evaluate the utilization and effectiveness of the HRSN services
- Data necessary to monitor health outcomes and quality of care metrics at the individual or aggregate level through MCO reported Encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities
- Data necessary to monitor appeals and grievances for members
- Documentation to ensure appropriate Social Risk Factors and clinical criteria for the medical appropriateness of HRSN services for each member
- Data determined necessary by OHIP or CMS to monitor and oversee HRSN initiatives

Additional details on data requirements from MCOs related to SCNs will be shared in the coming months.

e. MCO CONTRACT REQUIREMENTS WITH OHIP

i. MCO Reporting to OHIP

The Medicaid Managed Care Operating Report (MMCOR) Cost Report is a quarterly financial cost report that OHIP requires each Medicaid Managed Care Plan operating within the state to submit for each line of business that they operate. The cadence for report submission is as follows:

- Quarterly reports are submitted 45 days after the end of the respective quarterly report period (based on calendar year)
- Annual reports are submitted by April 1 of the following report period (based on calendar year)

OHIP will integrate the new HRSN services, funded through the Waiver, into this existing reporting. Guidance for how MCOs are to report on member enrollment, revenue, and expenses for these services will be included with the quarterly software release of Medicaid Managed Care Operations Report (MMCOR) software and instruction documents. An example of the latest MMCOR Guidance can be found on the Healthcare Financial Data Gateway (HFDG) located on the NYS Health Commerce System (HCS) website here. Users will need an HCS account to access these documents.

To meet these reporting requirements, MCOs will coordinate, accept, store, and report social care claims submitted to the MCOs by the SCN IT Platform. Together, the OSDS Encounter Standard Companion Guide (guides can be found here) provides instructions for how MCOs must report Managed Care encounter claims to OHIP. MCOs will work with SCNs to ensure any required data elements are provided to MCOs for submission to OHIP.

ii. MCO Member Communication Plan

MCOs will be expected to update their educational materials, with assistance from OHIP, to inform members about available SCN services. This may be an on-going task as requirements for SCN program participation progress or change. These materials will include (for specific deliverable dates, refer to the MCO Agreement):

- Create SCN and MCO presentation and other educational materials
- Update and revise member notice, member handbook insert, and obtain State approval to release material
- OHIP will ideally review and approve of member notice, handbook insert, presentation, and official plan notice prior to MCO implementation start date
- MCOs to send member notices and post the handbook insert on their website at least 30 days prior to the start of HRSN service delivery

iii. Medicaid Model Contract Policy Guidance

The Medicaid Managed Care plans will follow the Medicaid Model Contract as it relates to all Enhanced HRSN Services and associated workflows (e.g., social care claims acceptance and denial process, dispute process, payment calculations).

OHIP will take steps to amend the Model Contract to reflect the HRSN Screening and HRSN services including necessary workflows.

OHIP has provided policy guidance for MCOs. (*For more information, see SCN Contract Requirements with MCOs or refer to the MCO-SCN Agreement Template*).

iv. MCO Risk Adjustment

OHIP intends to include screening data collected through the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) tool into the State's managed care and managed long term care risk adjustment models, effective April 1, 2027.

The MCO's overall capitation rates will be directly associated to their attributed members with identified unmet needs per the 12 AHC screening questions listed in the SCN Operations manual.

~~i~~v. Medicaid Member Protections

Medicaid member protections include but are not limited to:

a. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid members' access to Medicaid covered services
b. Medicaid members always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option
c. Medicaid members who are offered or utilized an HRSN service retain all rights and protections afforded under 42 CFR 438
d. MCOs are not permitted to deny a Medicaid member who is eligible for a Medicaid covered service due to Social Risk Factors and clinical criteria on the basis that they are currently receiving HRSN services, have requested those services, or have previously received these services
e. MCOs are prohibited from requiring a Medicaid member to utilize HRSN services

f. SCN CONTRACT REQUIREMENTS WITH HRSN SERVICE PROVIDERS AND OTHER ENTITIES

The SCN Lead Entity is responsible for establishing a contracted network of organizations that has sufficient experience and training in the provision of Screening, Navigation, and Enhanced HRSN Service Delivery.

SCN Lead Entities are encouraged to utilize a template agreement when contracting with entities (*SCN Lead Entities can refer to the SCN-provider agreement Attachment shared by OHIP separately*). Agreements between the SCN Lead Entity and contracted organizations should authorize the exchange of Screening, Eligibility Assessments, referrals for Enhanced HRSN Services, and service provision data across the SHIN-NY, to the statewide data repository, and CMS.

The following section outlines a summary of contract expectations for the following types of organizations in the ecosystem:

i. HRSN service providers
ii. For-profit entities providing HRSN services
iii. Health care providers
iv. Medical Respite
v. Federally Qualified Health Centers (FQHCs)
vi. Certified Community Behavioral Health Clinics (CCBHCs)
vii. Health Homes (HHs)
viii. Care Coordination Organizations (CCOs)
ix. Article 36 Home Care Service Providers
x. Qualified Entities (QEs)
xi. Subcontractors
xii. Independent Physician Associations (IPA)
xiii. Institutional and residential facilities
xiv. Article 31 Office of Mental Health (OMH) facilities
xv. Article 16 Office of People with Developmental Disabilities (OPWDD) facilities
xvi. Article 32 Office of Addiction Services and Supports (OASAS) facilities

i. HRSN service providers

There is not a minimum or maximum number of HRSN service providers required in the SCN. HRSN service providers may contract with multiple SCN Lead Entities.

To join a network, HRSN service providers should fill out the "join our network" fillable form on the SCN LE's website. The SCN will contact the HRSN provider to discuss the organization's services and capacity. The HRSN service provider will then sign the templated HRSN service provider contract, submit any required documentation, and complete the training provided by the SCN. In tandem, the SCN will enroll the HRSN service provider on the platform. Once training is completed, the HRSN service provider will claim their profile on the platform and start services.

(*For more information on agreements between the SCN and HRSN service providers, see SCN-provider template agreement attachment*). This template agreement details contractual requirements expected of HRSN service providers. SCNs may use the template agreement but are not required to do so.

A non-exhaustive summary of SCN-HRSN service provider contracting expectations is below:

1. Medicaid Good Standing: The SCN Lead Entity must validate that the HRSN service provider is in Medicaid Good Standing prior to contracting. The SCN Lead Entity can utilize the Office of the Medicaid Inspector General's (OMIG) website to confirm Medicaid Good Standing: Search Exclusions (ny.gov)
   - HRSN service providers do not have to be Medicaid billing social care providers to join the SCN and this instance only applies to HRSN service providers conducting Medicaid services outside of the SCN Lead Entity's scope as a Tier 2 or Tier 3 CBO
   - Contracts with HRSN service providers should include the evaluation of the Medicaid Good Standing for any sister or parent agency associated with the CBO

2. HRSN service providers are expected to provide services in a manner consistent with the SCN program, including but not limited to:

- Agreed upon terms of service and anticipated payments during contract period;
- Compliance with necessary reporting requirements
- Submission of timely information as needed to facilitate reimbursement from SCN Lead Entity to the HRSN service provider for Enhanced HRSN Services provided
- Expectation to provide at least Screening, Navigation and/or one of the Enhanced HRSN Services and commit to accepting referrals in coordination with other SCN stakeholders
- Contribute to assessing capacity constraints and estimate need (if any) for capacity building funding from the SCN Lead Entity
- Understand option to reject any received referral and requirement to provide the rejection reason to the SCN Lead Entities
- Understanding that HRSN service providers are not permitted to provide Enhanced HRSN Services when already receiving payments or reimbursement from local, state, or federal sources for those services
- HRSN Service Providers or CBOs are allowed to bill for Enhanced HRSN Services rendered at the same address as a licensed clinic site under Article 28, 31, or 32 (including those funded by local departments of health)
- Requirement to maintain coverage areas that includes zip codes within the SCN Lead Entity region
- Designate contact(s) in their organization to engage and be trained on the SCN IT Platform and validate the accuracy of HRSN service provider information at routine intervals
- Be willing and able to receive training(s) on Screening members for HRSN with cultural and linguistic competency

3. Using the SCN IT Platform: HRSN service providers that are accepting referrals are required to be onboarded to the SCN IT Platform, with training support from the SCN Lead Entity. HRSN service providers are expected to have capability to operate within the SCN IT Platform and comply with all data requirements for Screening, Navigation, and Enhanced HRSN Service Delivery as needed

4. CBO Capacity Building: CBOs will be allocated infrastructure funding intended to support capacity building across the Network. Use of funds for capacity building can include, but is not limited to, hiring staff members, enrolling in the SCN IT Platform, or providing training across the organization

5. HRSN service provider subcontracting: The contract between the HRSN service provider and the SCN Lead Entity should have specifications for any subcontracting relationship and how that relationship is managed within the SCN IT Platform and for payment

ii. For-profit entities

SCN Lead Entities must contract and place preference upon using non-profit entities for Enhanced HRSN Services to ensure that small non-profits that are embedded in the communities being served are able to participate in the SCN. However, SCN Lead Entities are permitted to contract with for-profit organizations that are within their region to provide Screening, Navigation, and Enhanced HRSN Service Delivery. SCNs are expected to communicate to OHIP the rationale for inclusion of any for-profit entity.

Expectations are the same for both non-profit and for-profit entities; all guidance provided above for HRSN services providers is relevant for for-profit entities.

iii. Health care providers

SCN Lead Entities should coordinate closely with ecosystem partners such as health care providers, including health systems and independent practices. Health care providers that are contracted as part of the SCN and provide *only* Screening do not need to utilize the SCN IT Platform. However, for health care providers to conduct any other part of member journey (e.g., Eligibility Assessments, Navigation, and / or HRSN service delivery), the health care provider must onboard to and use the SCN IT Platform.

iv. Medical Respite

Medical Respites will have unique contract agreement components distinct from requirements of other SCN-contracted entities. Medical Respites contracted into the SCN are expected to:

- Create an emergency / disaster plan for members referred to Medical Respites by the SCN and accepted by the Medical Respites
- Establish a discharge plan within the SCN IT Platform's Social Care Plan to transition the member out of the Medical Respite and back into the community

In addition, the SCN Lead Entity is responsible for supporting Medical Respite referrals as follows:

- If the SCN receives a referral for Medical Respite and the member is found not eligible, the SCN Lead Entity must provide verbal and written notification to the referring entity on outcome of referral
- If a Medical Respite rejects the SCN's referral, the SCN must either
    - Outreach another Medical Respite that may accept the member, **OR**
    - when referral attempts have been exhausted, notify the referring entity of the unsuccessful attempts to find an appropriate Medical Respite via the SCN IT Platform
- AND provide verbal notification to the member

v. Federally Qualified Health Centers

FQHCs may contract with SCN Lead Entities to participate in the Network. Contracted FQHCs that are part of the Network may be reimbursed for Screening, Navigation, and Enhanced HRSN Services.

FQHCs may be reimbursed for SCN services only if those services have not been reimbursed by Medicaid FFS, Medicaid Managed Care, or a third-party payer. Screening, Navigation, and Enhanced HRSN Services provided on the same day as a threshold visit are not considered covered under Medicaid FQHC Prospective Payment System (PPS) reimbursement and remain eligible for separate SCN reimbursement.

Additionally, FQHCs should not report visits and revenue associated with SCN services on the Managed Care Visit and Revenue (MCVR) report as these services are not eligible for the Supplemental Payment Program. Medicaid PPS threshold visits remain eligible for the Supplemental Payment Program, further distinguishing these services from SCN reimbursements. Visits and revenue associated with SCN services should not count towards participation in federal programs.

FQHCs are not considered part of the 51% CBO representation required of the SCN Lead Entity's governing body. FQHCs would be considered as a "Health Care and Care Management Social Care Provider" member of the SCN governing body.

vi. Certified Community Behavioral Health Clinics (CCBHCs)

SCN Lead Entities are encouraged to contract with Certified Community Behavioral Health Clinics (CCBHCs) in their region. Contracted CCBHCs may provide Screening, Navigation and Enhanced HRSN Services. CCBHCs that do not wish to contract with SCN LEs are encouraged to direct members to SCNs for Screening and services.

Individuals receiving services from a NYS CCBHC are NOT excluded from the services and resources offered through NYHER Social Care Networks (SCNs), including but not limited to Nutrition, Housing, and Transportation services. Individuals receiving CCBHC services can be connected to SCNs and receive appropriate screenings to determine eligibility for social care services and resources.

For CCBHCs that contract with SCN Lead Entities:

- Screening:
  - Given that CCBHCs already conduct HRSN screening, CCBHCs may:
    - Add additional questions to existing screening process to align with the AHC Screening Tool and ensure complete screening
    - Ensure screening follows coding requirements by submitting SHIN-NY member consent ("Question 0") along with screening data using the AHC Screening Tool
  - Contracted CCBHCs can be reimbursed for HRSN Screening if they:
    - Use the required AHC tool and follow associated data sharing requirements
- Navigation:
  - CCBHCs must be onboarded onto the SCN IT Platform to provide Navigation or Enhanced HRSN Services
  - CCBHCs may be reimbursed through NYHER for time spent:
    - Conducting an Eligibility Assessment in SCN IT platform
    - Referral of members to Enhanced HRSN Services in the SCN IT Platform
    - Ongoing engagement with members related to Enhanced HRSN Service Delivery
    - Referral closure in the SCN IT Platform
  - CCBHCs may NOT be reimbursed through NYHER for time spent:
    - Navigating members to existing federal, state, and local services. This service is already provided by CCBHCs and reimbursed as part of Targeted Case Management

CCBHCs that do not contract with SCN Lead Entities will not be reimbursed for any Screening, Navigation, or HRSN services.

vii. Health Homes

SCNs are strongly encouraged to contract with all HHs in their region. HHs inclusive of their subcontracted CMAs that are contracted to participate with the SCN Lead Entity may provide Screening, Navigation and Enhanced HRSN Services. Health Homes that do not wish to join the SCN are encouraged to direct members to the SCN for Screening, Navigation, and services not offered through the HH. References to HHs in this section refer to the HH organization in its entirety, including any subcontracted entities within the HH. HHs can start to receive

payment for services delivered through the SCN Program (e.g., Screening, Navigation, Enhanced HRSN Services) as of January 1, 2025. Health Homes and their subcontracted CMAs may do either Screening, Navigation, or Enhanced Care Management or choose to do all these activities.

Table 8-2: NYHER reimbursement of Health Homes for activities across the member journey

Steps in SCN member journey and relevant fee schedule section *Definitions*	**Reimbursable via NYHER** *Applies to Health Homes serving adults & children*		**Fee schedule rate**
	Medicaid members enrolled in Health Homes	**Other Medicaid members not enrolled in Health Homes**	
Screening (Service 0) *Time spent explaining the SCN program to a member, walking through the Screening with the member, obtaining consent, inputting the member's information and answers to Screening questions, and responding to the member's questions about next steps*	**Can** be reimbursed via NYHER if following SCN guidelines	**Can** be reimbursed via NYHER	$17.50/15 min, up to $35 per Screening
Navigation to Existing Federal, State, and Local Services (Service 1.1) *Assessment and connection to existing services provided by the federal, state, or local programs*	**Cannot** be reimbursed via NYHER	**Can** be reimbursed via NYHER	$17.50/15 min, up to $70 per event
Enhanced Population Eligibility Assessment (EA) (Service 1.2a) and Navigation to Enhanced HRSN Services (Service 1.2b) *Assessment of the enhanced population member's eligibility for NYHER-financed Enhanced HRSN Services conducted by a Social Care Navigator. Connection and referral to NYHER Enhanced HRSN Services*	**Can** be reimbursed via NYHER	**Can** be reimbursed via NYHER	$17.50/15 min, up to $350 per month
Enhanced HRSN Care Management (Service 1.2b) *Care Management for members eligible for Enhanced HRSN Services includes referral management, follow-up, and Social Care Plan completion*	**Can** be reimbursed via NYHER	**Can** be reimbursed via NYHER	

*Note Medicaid members not enrolled in Health Homes are covered if part of another Enhanced Population eligible to receive Enhanced HRSN Services.

One contract between an SCN Lead Entity and a Health Home may apply to and cover all Care Management Agencies (CMAs) that are part of the HH for Screening and Navigation. CMAs that perform functions in addition to Screening and Navigation (e.g., Enhanced HRSN services such as Pantry Stocking, MTMs) will need to contract directly with the SCN Lead Entity.

Health Homes that are part of an SCN or serving as an SCN Lead Entity

Screening:

- HHs that are a part of an SCN should screen members for HRSNs. Given that HHs already conduct HRSN Screening as part of the HH comprehensive assessment, HHs may:
    - Add additional questions to their existing Screening process (e.g., education and employment) to align with AHC Screening tool and ensure a complete Screening
    - Ensure Screening follows coding requirements by submitting SHIN-NY member consent ("Question 0") along with the Screening data using the AHC Screening Tool
    - Either complete Screening directly in the SCN IT platform OR an interoperable platform, working with a QE to ensure data quality standards are met and that the Screening can be ingested into the SCN Program's data lake
- HHs can start to receive payment for Screening by January 1, 2025, for any Screenings consistent with requirements for reimbursement (see Screening Methodology section for requirements for reimbursement)

Navigation:

- HHs contracted into the SCN can conduct Navigation for both members of the HH and members outside of the HH
- HHs contracted to provide Navigation or Enhanced HRSN Service must be onboarded on to the SCN IT Platform
- As a best practice, if a member navigated to Enhanced HRSN Services is identified as HH member, the Social Care Navigator should contact the member's known Health Home care manager to ensure awareness of SCN navigation and services and to seek input as appropriate for coordinated care
    - For existing HH members, HHs may include social care goals from the existing care plan in the SCN Social Care Plan to reduce duplication in care planning activities
    - For new HHs members without existing care plans, Health Homes may decide to distribute goals across care plans (e.g., clinical goals in Health Home care plan and social care goals in SCN Social Care Plan)
- HHs that are contracted within the SCN will be reimbursed for:
    - Screening consistent with requirements for reimbursement (see Screening Methodology section for requirements for reimbursement)
    - Navigation to Enhanced HRSN Services for members that are eligible as determined by a Social Care Navigator during the Eligibility Assessment, including:
    - Conducting an Eligibility Assessment in SCN IT platform
    - Creation of a Social Care Plan for members in the SCN IT Platform
    - Referral of members to Enhanced HRSN Services in the SCN IT Platform
    - Ongoing engagement with members related to Enhanced HRSN Service Delivery

    - Referral closure in the SCN IT Platform
- HHs that are contracted within the SCN will NOT be reimbursed for:
    - Navigation to existing federal, state, and local services (given this service is already being provided by HHs) for members that are NOT eligible for Enhanced HRSN services from the SCN program

Health Homes that are NOT part of SCN

HHs that are NOT in the SCN will NOT be reimbursed for any Screening, Navigation, or HRSN services.

HHs that are not part of an SCN will not receive waiver funding to establish a two-way data exchange with the SHIN-NY via QEs. HHs are encouraged to contract with QEs to upload Screening data that can be shared into the SHIN-NY data lake.

HH specific questions outside of partnership with the SCN should be sent to: healthhome@health.ny.gov.

vii. Care Coordination Organizations (CCOs)

SCN Lead Entities are encouraged to contract with Care Coordination Organizations (CCOs) in their region. Contracted CCOs may provide Screening, Navigation and Enhanced HRSN Services, and will have access to member's Social Care Plan. CCOs that do not wish to contract with SCN LEs are encouraged to direct members to SCNs for Screening and services. CCOs contracted to provide Navigation or Enhanced HRSN Services must be onboarded onto the SCN IT Platform.

Individuals receiving services from a NYS CCO are NOT excluded from services and resources offered through Social Care Networks (SCNs), including but not limited to Nutrition, Housing, and Transportation services. Individuals receiving CCO services can be connected to SCNs and receive appropriate screenings to determine eligibility for HRSN services and resources.

As a best practice, if a Medicaid member being navigated to Enhanced HRSN Services is identified as enrolled in a CCO, the Social Care Navigator should contact the member's known CCO care manager to ensure awareness of SCN navigation and services and to seek input as appropriate for coordinated care.

CCOs cannot receive reimbursement through SCN program for time spent navigating members to existing federal, state, and local services for members currently enrolled in the CCO program.

ix. Article 36 Home Care Services Providers

Article 36 Home Care Services Providers / Home Health Agencies can be an SCN-contracted partner if they are providing a separate and distinct activity outside of current billable services already covered for by any local, state, or federal payments.

x. Qualified Entities

SCNs must partner with QEs to send HRSN data to the NYeC/SHIN-NY Data Lake. (*If an SCN is not yet connected with a QE, visit "How to Connect & Use the SHIN-NY" at https://www.nyehealth.org/shin-ny/connect-use/*). From

here, entities can navigate to each QE's homepage. Once the SCN Lead Entity contract is executed, SCN Lead Entities have until they start delivering services to connect their SCN IT Platforms with a QE.

SCN Payments for QE Services

SCN payments to QEs may not be used to fund the same service currently funded by OHIP through the SHIN-NY's State Designated Entity. Current services funded through the SHIN-NY include exchange of HRSN data, consent management, SCN / CBO access to clinical data, HRSN data display and query, data quality validation services and FHIR transformation. Any value-added services beyond these core functions may have a cost associated.

MMC Eligible Enhanced Services Member File

(*For more information on QE's role with the Enhanced Services Member File, see the section Enhanced Services Member File*)

QE / SCN Lead Entity Communication Failures

In the event there is a QE Communication Failure with retrieving the Enhanced Services Member File from the NYeC/SHIN-NY data lake QEs will relay this information to the New York eHealth Collaborative and OHIP, and also their regional SCN Lead Entity.

QE Participation Agreement

SCN Lead Entities will need to sign a QE Participation Agreement with the QE partner(s) of their choice. All QE PAs include some provisions that are common and consistent across the SHIN-NY. The PA will require both parties to comply with applicable provisions of the SHIN-NY Policies and Procedures, including those that protect the security and privacy of patient data. PAs also include the terms of a Business Associate Agreement (BAA) which defines certain ways an entity covered by HIPAA will handle data.

SCN Lead Entities will need to sign an addendum to the QE Participation Agreement that includes terms which will be common across all QEs and SCN Lead Entities. The addendum will support the exchange of HRSN data including but not limited to Screenings, Eligibility Assessments, and referrals as defined by the Operations Manual and will specifically address:

- A QE's allowable uses of the HRSN data it receives from an SCN Lead Entity
- An SCN Lead Entity's allowable uses of the HRSN data it receives from a QE
- Additional privacy and security safeguards for HRSN data, if applicable

The addendum terms will be developed by the program office. SCN Lead Entities should anticipate that the addendum will define the allowable uses of HRSN data tightly and that it will reference a statewide and transparent process within the SHIN-NY to make further determinations about allowable uses of HRSN data. The addendum will further:

- Require the QE to (1) transfer and contribute SCN clients' HRSN data provided by the SCN Lead Entity to the SHIN-NY statewide data repository (SHIN-NY Data Lake), and to Medicaid, and (2) authorize appropriate access, use, disclosure, and re-disclosure of such data
- Require QE and SCN Lead Entity adherence to data standards and quality as defined by the Operations Manual and contracts

    - QEs and SCN Lead Entities must adhere to the 1115 SHIN-NY FHIR Implementation Guide and terminology as defined in the Operations Manual and contracts
- Specify a QEs role in delivering the Medicaid Eligibility Files and monthly Enhanced Services Member Files *(see Agreement 3 below)*

QE / SCN NYHER Addendum to QE Participation Agreement

The NYHER Addendum is an OHIP-approved Addendum that all SCNs will sign with its partner QE(s). Each SCN and QE will have a Participation Agreement in place, which may be unique to each QE. However, the Addendum sets forth the terms and conditions under which certain data contributed to and received from the SHIN-NY may be accessed. This is used and disclosed for purposes of the New York Health Equity Reform 1115 Waiver including transmittal to OHIP for program oversight.

xi. Subcontractors

Subcontractors may include IT vendors, for-profits, etc. The use of subcontractors and the activity they will be performing should be indicated within any contract or agreement.

xii. Independent Practice Associations (IPAs)

IPAs may contract with an SCN Lead Entity to conduct Screening and Navigation or may contract with an SCN Lead Entity on behalf of their IPA members. If contracting on behalf of its members, the IPA must ensure that an appropriate data agreement, such as a Business Associate Agreement, is in place between the IPA and its members. By virtue of contracting with the IPA, the SCN will not need to sign individual contracts with the IPA's members. If requested by the SCN, IPAs should supply copies of their subcontracts to the SCNs.

IPAs may send Screening data on behalf of their IPA members to the SCN IT Platform, the SCN Lead Entity, or the SHIN-NY (as mutually determined and agreed upon by the SCN and IPA).

The IPA may receive payment on behalf of IPA members and is responsible for appropriately distributing payments to its IPA members. IPAs will not receive administrative payments from the SCN Lead Entity.

xiii. Institutional and residential facilities

SCN Lead Entities are encouraged to partner with institutional and residential facilities to coordinate services for eligible members (e.g., transitioning out of institutional care settings). Screening, Navigation, and Enhanced HRSN Services will not be reimbursed for individuals residing in institutional and residential facilities.

xiv. Article 31 Office of Mental Health facilities

Outpatient OMH facilities under Article 31 may be reimbursed for Screening and Navigation if contracted with a Social Care Network. OMH providers that do not wish to join the SCN are encouraged to direct members to the SCN.

Screening, Navigation, and Enhanced HRSN Services may not be reimbursed for individuals residing in an OMH facility or state psychiatric facility (*see section on Medicaid Member Eligibility*).

Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Program

MHOTRS providers can assist and receive reimbursement for screening, navigation, Enhanced HRSN Services including Enhanced Care management. MHOTRS providers that do not wish to join the SCN are encouraged to direct members to the SCN.

xv. Article 16 Office of People with Developmental Disabilities (OPWDD) facilities

Outpatient OPWDD facilities under Article 16 may be reimbursed for Screening and Navigation if contracted with a Social Care Network. OPWDD providers that do not wish to join the SCN are encouraged to direct members to the SCN.

Screening, Navigation, and Enhanced HRSN Services may not be reimbursed for individuals residing in an OPWDD facilities (*see section on Medicaid Member Eligibility)*.

xvi. Article 32 Office of Addiction Services and Supports (OASAS) facilities

Outpatient OASAS facilities under Article 32 may be reimbursed for Screening and Navigation if contracted with a Social Care Network. OASAS providers that do not wish to join the SCN are encouraged to direct members to the SCN.

Screening, Navigation, and Enhanced HRSN Services may not be reimbursed for individuals residing in an OASAS facilities (*see section on Medicaid Member Eligibility)*.

9. DATA GOVERNANCE, PRIVACY, AND SECURITY

Data governance, privacy, and security sub-sections:

a. Introduction

b. Data Governance Framework

c. Data Privacy and Security

d. Data Sharing – Interoperability

e. Data Sets, Terminologies, and Coding

f. Data and Systems Implementation Guide

a. INTRODUCTION

The SCN Lead Entity's Data Governance is the collection of policies and procedures that standardize data management, advance interoperability, and ensure secure data distribution of HRSNs. The importance of safeguarding sensitive information and ensuring regulatory compliance cannot be overstated. The data governance frameworks ensure that all the data collected, stored, and shared within the SCN Lead Entity and exchanged between the SCN Lead Entities and other stakeholders is handled responsibly and securely. Data governance provides the decision-making processes for the SCN Lead Entity governing body and its appointees to ensure that data is consistent, complete, interoperable, secure, discoverable, and trustworthy.

Data privacy and security are crucial for the SCN Lead Entity to protect sensitive member information from being misused or accessed by unauthorized people. The SCN Lead Entity will need to implement OHIP Statewide Health Information Exchange Privacy and Security Policies and Procedures outlined in full here: https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf. A summary list of compliant safeguards includes but are not limited to federal, state laws and regulations, HIPAA, ISO 27001, NIST 800-53, and SOC2/3 safeguards to protect electronic health information. These safeguards include administrative measures (like training staff), physical measures (like securing buildings), and technical measures (like encrypting data).

The SCN Lead Entity is required to establish a connection with a Qualified Entity of its choice that is recognized by OHIP. This connection is crucial for ensuring seamless communication and information sharing among stakeholder systems. Interoperability involves the SCN Lead Entity's ability to connect, transmit, and retrieve information through the SHIN-NY. SHIN-NY is a secure network designed for sharing electronic health care records, and it now includes data related to HRSN for NYHER demonstration purposes. The Office of Health Services Quality and Analytics has partnered with the New York eHealth Collaborative (NYeC, pronounced "nice") to implement the SHIN-NY. NYeC is a non-profit organization working in partnership with New York State to improve health care collaboratively by leading, connecting, and integrating health information exchange (HIE) across the state and facilitating the sharing of information with health care providers and systems. This collaboration aims to improve the management of Medicaid members' HRSNs. By leveraging access to comprehensive and up-to-date member records in SHIN-NY, Social Care Navigators can access member information, which enhances their ability to deliver coordinated care in a timely and effective manner.

b. DATA GOVERNANCE FRAMEWORK

i. Data governance structure

The SCN Lead Entity shall establish decision-making processes for the network across institutional, administrative, and data governance. Institutional governance sets the framework for participation, leadership organization, priority setting, rulemaking, outcome evaluation, and conflict resolution. Administrative governance translates institutional policies into actionable plans, ensuring compliance, information sharing, and operational standards. Data governance involves implementing and enforcing these policies through meticulous data stewardship, including managing data collection, storage, exchange, and deletion. Effective governance ensures that all levels work cohesively to facilitate transparent and accountable decision-making processes. (*See also the role of the ii. Health Equity Regional Organization* (HERO)~~*ii. Health Equity Regional Organization* (HERO).~~

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ii. Data ownership

An SCN Lead Entity shall own its data. However, SCN data may only be shared with approved entities for purposes of meeting SCN programmatic objectives and cannot be shared or used for commercial purposes. Data will not be considered "Medicaid Data" and owned by OHIP until it reaches New York State's Medicaid Data Warehouse (MDW). HRSN data generated through the SCN Lead Entity will be owned by the originating entity until there is a disclosure and/or transmittal from the SHIN-NY to New York State's Medicaid program. Once HRSN data is transmitted to New York State's Medicaid program, the data will be considered owned and governed by OHIP.

iii. Data stewardship and oversight

The SCN Lead Entity shall establish data stewardship processes in compliance with the technical standards, data collection, management, storage, exchange, verification, validation, contestation, and deletion established by OHIP.

c. DATA PRIVACY AND SECURITY

i. Introduction

SCN Lead Entities' data privacy and security will be governed by NYS Health IT regulations, NYS Department of Health Office of Health Insurance Programs Division of Operations and Systems (DOS) Security and Privacy Bureau, NYS Privacy and Security Guidance for QEs and their participants (SCNs) and other applicable federal and state laws and regulations for privacy and security. Federal and state laws provide specific protections for people enrolled in the Medicaid program to ensure that sensitive data, including PHI and Personally Identifiable Information (PII), is shared only under specific conditions. All participants must adhere to the HIPAA Privacy and Security Rules, implementing necessary safeguards for PHI protection. In addition, SCNs are required to adhere to all applicable federal and state regulations (examples include 42 CFR Part 2, NYS MHY 33.13, and NYS PHL 2782).

SCNs must obtain affirmative consent before disclosing Screening, Navigation, referral or service provision data via the SHIN-NY. Role-based access standards ensure that only authorized individuals can access PHI based on their job functions. Authentication methods include unique usernames and passwords with strict security measures. Members must be informed of their rights and the consent process, and SCNs are required to facilitate member access to their PHI through various mechanisms. To ensure compliance and security, SCNs must maintain detailed audit logs of PHI disclosures and conduct regular audits with publicly available results. Breach response plans are essential, with prompt notification to affected parties and regulatory agencies in case of a breach.

SCNs are also required to establish procedures for monitoring violations of privacy and security policies. SCN must develop comprehensive cybersecurity policies aligning with applicable federal and state laws and regulations including NIST Cybersecurity Framework standards to protect the SCN and the SHIN-NY enterprise.

For more detail on the NYS Privacy & Security Policies and Procedures governing SCNs, visit:

- New York State Health Information Technology Regulations and Resources
- Privacy & Security Policies and Procedures

ii. Member Consent Management

SCNs are required to obtain affirmative member consent before disclosing PHI through the SHIN-NY, except under specific circumstances such as emergencies or public health reporting. Exceptions to this member consent requirement include one-to-one exchanges, public health reporting, emergency disclosures, data conversion, and other specified scenarios. Policies must ensure that sensitive health information, including mental health and substance abuse data, is disclosed only under stringent conditions. Special provisions must be in place to govern access to minor member consent information, ensuring compliance with applicable laws. (*For additional details, see the Consent section of this Manual*).

iii. Authorization, Authentication, and Access

The SCN Lead Entity shall authorize which entities have authorization, authentication, and access to SCN data by September 30, 2024.

SCNs must implement role-based access standards to ensure that only authorized individuals, based on their job functions and relationship with the member, can access PHI including but not limited to:

- **Authorization:** Authorized users must be assigned unique usernames and passwords, with strict controls on password strength, sharing, and periodic changes. Access to PHI must be limited to the minimum necessary information required for the intended purpose.
- **Role-based access control:** SCN IT Platform will support differential views by user access type (e.g., SCN Lead Entity may choose to have performance data, member information, etc. only visible to certain users)
    - Allow specific users to view latest and historical Screening status and Screening results, based on ability to receive pushed extracts, and pull historical data by querying QE portal
    - Allow specific users to view and update Screening results

SCNs and participants must authenticate the identity of authorized users before granting access to PHI, utilizing methods that meet the standards outlined in NIST Special Publication 800-63.

- **Authentication:** SCN Lead Entity staff will have assigned and authenticated users. SCN Lead Entities will authenticate SCN IT Platform users only if users have completed required training in the established SCN Data Collection, Use, and Sharing policies.

SCNs must ensure that only approved entities and their staff who have gone through the appropriate training, authentication, and have access to licenses, and shall be allowed to input and exchange Eligibility Assessment data and care planning notes related to social care with ecosystem partners.

- **Access:** to the SCN IT Platform will be obtained through licensing provided by the SCN Lead Entity to participating entities
- **Data Privacy & Security Training:** SCN Lead Entity staff will have SCN IT Platform training requirements to gain access to their assigned role-based access control

iv. Member education, engagement, and access

Prior to Screening, SCNs must first ask 'Question 0' to obtain member consent. Question 0 provides a high-level overview of how the member's data may be used. SCNs can provide the member their longer form Notice of Privacy Practices should the member request a more detailed explanation. SCNs must facilitate member access to their PHI through various mechanisms, ensuring members can direct their information to third parties, including member applications. For additional information on Question 0 see Member Consent for Screening and Screening conducted outside the SCN IT Platform.

v. Audit

SCNs must maintain detailed audit logs of all PHI disclosures, including information on who accessed data and when. Regular audits must be conducted to ensure compliance with policies and procedures, with results made publicly available.

SCN Lead Entities will create the content for and conduct periodic audits of each of their network participants to monitor use of the SCN IT Platform, their Authorized Users, and ensure compliance with the Policies and Procedures and all applicable laws, rules, and regulations.

vi. Prohibited Uses:

The following uses of SCN Data are prohibited:

- The sale of individually identifiable information (including but not limited to PHI and PII);
- The use of individually identifiable information for marketing purposes that would require an authorization under 45 C.F.R. § 164.508(a)(3); and
- Any purpose prohibited by applicable law

vii. Breach

SCNs must develop breach response plans and promptly notify affected parties and regulatory agencies in the event of a PHI breach. The SCN must notify the Security and Privacy Bureau and the NYHER program of a possible event or security breach within 24 hours of identification of indicators of compromise. The Security and Privacy Bureau shall be notified at doh.sm.Medicaid.Data.Exchange@health.ny.gov and IncidentReport@health.ny.gov.

viii. Compliance and Certifications

HIPAA Compliance

HIPAA sets the standard for protecting health-related and social care data, the non-medical factors that influence health outcomes. Any organization dealing with PHI must ensure that all the required physical, network, and process security measures are in place and followed.

The SCN Lead Entity shall ensure the IT Platform is HIPAA compliant for all participants in its network, regardless of whether they are covered entities all network participant stakeholders must comply with HIPAA Privacy and Security Rules and adopt necessary safeguards to protect PHI.

If the SCN IT Platform is not currently HIPAA compliant, the SCN shall outline its approach to ensuring the IT Platform becomes HIPAA compliant by 9/30/24.

The SCN Lead Entity is required as per HIPAA to assess their own compliance, and at this time a compliance assessment does not need to be provided to OHIP.

State Regulations

There are two regulations that are currently in the process of being amended:

1. Amends Title 300 -SHIN-NY to reforming the structure of the SHIN-NY including emphasizing the aggregation of data to support SCN Lead Entity reporting to Medicaid via the SHIN-NY. (Adopted June 20, 2024). For additional information see: DOS, 2024. State Register XLVI (28). Albany (NY): New York State Department of State
2. Amends Section 504.9 of the social services regulation to allow claims data to flow via the SHIN-NY and to be released with consent (~~Released for public comment on June 26, 2024~~Adopted November 6, 2024). For additional information see: DOS, 2024. State Register XLVI (45). Albany (NY): New York State Department of State ~~DOS, 2024. State Register XLVI (26). Albany (NY): New York State Department of State~~

ISO 27001 Certification

ISO 27001 Certification ensures that an organization has implemented an effective Information Security Management System (ISMS).

SOC 2/SOC 3 Certification

SOC 2/SOC 3 Certification assesses the effectiveness of a vendor's systems in managing customer data.

ix. Sanctions

SCN Lead Entity shall be subject to sanctions from OHIP for violation of privacy and security policy. The SCN Lead Entity must establish policies for sanctioning network participants and authorized users who violate privacy and security policies, considering factors such as the severity and frequency of violations.

d. DATA SHARING - INTEROPERABILITY

i. HL7 FHIR National Standards compliance

The SCN Lead Entity shall be capable of bi-directional data exchange for HRSN information using Health Level 7® (HL7) Gravity Project® FHIR standards. The Gravity Project exists to serve as the open public collaborative advancing health and social data standardization for health equity. Their goal is to build and promulgate consensus driven data standards for health and social care interoperability and use among multi-stakeholders. SCN IT Platforms should be able to demonstrate competency with national HL7 FHIR standards **by October 31, 2024**. SCN Lead Entities who are not FHIR enabled within the required time may have transactions rejected. SCN Lead Entities and their IT Platform partners can access this information at: https://shinny.org/us/ny/hrsn/index.html.

- SCN Lead Entities may share data with QEs and other stakeholders in other standardized formats (e.g., JSON flat file, Excel file) while they work towards implementing HL7 FHIR standards.
- SCN Lead Entities will be expected to be capable of transmitting data to the SHIN-NY data lake using FHIR-based data exchange standards and adhering to the FHIR Implementation guide found here https://shinny.org/us/ny/hrsn/index.html
- Once the SCN Lead Entity contract is executed, SCN Lead Entities have until they start delivering services to connect their SCN IT Platforms with a QE

ii. QE Connectivity

SCN Lead Entities will need to partner with a Qualified Entity to send HRSN data to SHIN-NY Data Lake. If SCN Lead Entities are not yet connected with a QE, please visit "How to Connect & Use the SHIN-NY" at https://www.nyehealth.org/shin-ny/connect-use/. From here, SCN Lead Entities can navigate to each QE's homepage. SCN Lead Entities and their IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/.

iii. 1115 SHIN-NY Interoperability

SCN Lead Entities must establish interoperability by the time they start delivering services. For those already connected to a QE, HRSN data can be sent as early as **October 1, 2024.** Through the set of participation agreements established across key stakeholders (e.g., SCN Lead Entity QE, and MCO) all entities must adhere to SHIN-NY data privacy and security policies and New York State's guidance. SCN Lead Entities and their IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/.

iv. 1115 SHIN-NY Interoperability Guidance

The SHIN-NY partnered with OHIP, the Gravity Project, and Civitas Networks for Health to develop HRSN data standards for New York's 1115 Waiver. SCN Lead Entities and their IT Platform partners can access this information through the 1115 SHIN-NY FHIR Implementation Guide (IG) https://shinny.org/us/ny/hrsn/index.html and New York eHealth Collaborative's website https://www.nyehealth.org/1115-waiver/. Access to a terminology repository, validation rules, and other interoperability standards will be available in this FHIR IG and on the NYeC website. This will capture the data terminology and exchange standards as outlined throughout this Requirements Document.

Please note that certain resources are not publicly available, but NYeC is able to provide access to SCN Lead Entity staff, as well as SCN IT partners. If SCN Lead Entities or SCN IT partners are not able to open a document on NYeC's 1115 website, please contact 1115-waiver@nyehealth.org to request access. New York eHealth Collaborative will be hosting an 1115 SHIN- NY Interoperability Workgroup to solicit feedback and review content.

e. DATA SETS, TERMINOLOGIES, AND CODING

i. Introduction

To enhance communication and coordination, streamline data collection and analysis, facilitate billing processes, support research and policy development, and ensure compliance with legal and regulatory requirements, OHIP has chosen to use coded terminologies to map social care activities to HRSNs. This approach will improve the efficiency and effectiveness of services provided.

In addition to terminology standards, OHIP has developed a minimum viable dataset (MVD) that will be utilized to ensure specific data elements needed for Medicaid capture, analysis, and CMS reporting are being sent by the organizations involved in the 1115 Waiver. The MVD will include member and organization attributes needed during each HRSN data step as well as data elements that should be contributed for Screenings, assessments, and referrals. The MVD is only applicable and required for data submitted via SCN IT Platforms.

SCNs will adopt consensus-based, coded terminology standards and the minimum viable data set for social care activities to support the collection, use, and exchange of data to address social determinants of health for social care and payment data. The Gravity Project is leading the consensus-driven standards for health and social care interoperability. The terminologies used are available from the UMLS Terminology Services website. SCN Lead Entities and their IT Platform partners can access this information and will have access to the terminology below and a minimum viable data set through the SHIN-NY and 1115 Waiver specific implementation guides for coded terminology uses found on NYeC's NYHER 1115 Extranet. Please make sure SCN technical teams have access. If you do not, please reach out to 1115-waiver@nyehealth.org.

LOINC used for identifying health

Measurements, observations, and documents (e.g., AHC HRSN tool). LOINC standardizes coding for SDOH data elements such as housing status, food security, transportations access, social connection, and education level.

ICD-10-CM (International Classification of Diseases, Clinical Modification)

Primarily used for diagnosis coding, these are used to classify outcomes related to SDOH using Z55 – Z65 codes. These Z-codes cover issues related to education, literacy, employment, housing, financial, and social circumstances of members.

SNOMED-CT[4] (Systematized Nomenclature of Medicine – Clinical Terms)

Provides codes, terms, synonyms, and definitions used in clinical documentation and reporting for conditions, health concern, problem, diagnosis, assessment, goal, reason for service request, or procedure.

Health care Common Procedure Coding System (HCPCS)

HCPCS is a set of procedure codes based on Current Procedural Terminology for claim submission and reimbursement for services. The HRSN codes play a crucial role in the documentation and billing for HRSN activities. These activities address the social determinants of health that significantly impact member outcomes. HCPCS codes for HRSN activities cover coordination, provision, and reimbursement for transportation services, nutritional support, home modifications, substance abuse intervention, mental health counseling, personal care services, and disease management education.

HL7 FHIR

While not terminology per se, HL7 FHIR standards are crucial for the interoperability aspect of SDOH data. FHIR standards facilitate the exchange of health care information electronically, and the Gravity Project leverages these standards to ensure that SDOH data can be seamlessly integrated and shared across different health systems.

Coding may be conducted by any contracted Social Care Navigator that agrees under contract to receive SCN IT Platform training and unique user roles to perform Eligibility Assessment and coding.

OHIP has shared the following required coding with the SCN's IT Platform. The standardized coding includes Screening, Eligibility Assessment, Navigation, referral, Enhanced HRSN Service completed, and reimbursement.

Table 9-1: Standardized terminologies and codes for SCN IT Platform

CARE DELIVERY APPROACH	SOCIAL CARE CODES	BILLING CODES
Screening	LOINC CD	**FFS:** HCPCS + State Defined Modifiers **Managed Care:** HCPCS + State Defined Modifiers
Eligibility Assessment	SNOMED CT & ICD-10 (Z Codes)	See "Service Navigation / Care Management"
Person-Centered Goals	SNOMED CT	N/A
Service Navigation / Care Management	SNOMED CT	**FFS:** HCPCS + State Defined Modifiers **Managed Care:** HCPCS + State Defined Modifiers

4 This material includes content from the US Edition to SNOMED CT, which is developed and maintained by the U.S. National Library of Medicine and is available to authorized UMLS Metathesaurus Licenses from the UTS Downloads site at https://uts.nlm.nih.gov.

CARE DELIVERY APPROACH	SOCIAL CARE CODES	BILLING CODES
HRSN Referral	SNOMED CT	N/A
HRSN Service Provision + Claims / Remittance	SNOMED CT	**Managed Care:** HCPCS + State-Defined Modifiers, Rate CD (Medical Respite)

OHIP will use separate codes to identify and keep track of FFS Medicaid members. These members can only get certain services like Screening and help finding existing program resources (e.g., SNAP, TANF, etc.). OHIP will use these codes to look at the medical information and find out what social needs are not being met in different communities. This will help OHIP understand how many people need help, what kind of help they need, and for how long. OHIP will also use this information to check how well the NYHER programs are working and to make improvements.

For additional information on coding specifications and implementation guidance, SCN Lead Entities and their IT Platform partners can access this information on NYeC's NYHER 1115 Extranet. OHIP will publish a publicly available HRSN fee schedule (including billing codes) ~~prior to service go live~~on a quarterly basis.

Screening to Services Mapping: This document is a comprehensive view of consensus-based, standardized NYHER social care codes (e.g., LOINC, ICD-10, SNOMED CT) and HRSN billing codes (e.g., HCPCS and New York State-defined modifiers, rate codes) to utilize throughout the NYHER member journey from the Screening activity through the Billing activity.

SCNs should reference this document to understand the breadth and scope of social care codes that must be built into their SCN IT Platform to effectively document unmet social needs and actions taken to address needs in electronic systems. The document is organized horizontally by each individual AHC HRSN Screening Tool question, detailing all codes associated with each potential member response across NYHER activities. The Social Care Navigator can use this document as a reference to see the universe of social care codes built into the platform on the back end by first locating the member's positive need(s) from the AHC Screening Tool within this document. From the member's identified positive response(s), the Social Care Navigator should progress horizontally to select a suitable code(s) for each subsequent activity. While this document provides the most likely and appropriate mapping of codes between activities, the uniqueness of Social Care Navigator/member interactions may result in coding which deviates from the recommended mapping of codes.

Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the live document on NYeC's NYHER 1115 Extranet.

NYHER Social Care Coding: This document is a vertically oriented version of the Screening to Services Mapper document. It is also a comprehensive view of nationally validated, standardized NYHER social care codes to utilize throughout the NYHER member journey from the Screening activity to the Services activity. This document excludes the associated HRSN billing codes. It is organized by NYHER activity type (Screening, Assessment, Goals, Navigation, Referral, Services). This document will be updated as a subset of SNOMED codes are published and required to replace local codes currently listed.

Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the live document on NYeC's NYHER 1115 Extranet.

ii. Screening for Social Risks: LOINC Codes

The SCN IT Platform will be used for Screening. It must have the capability to map each individual question from the AHC HRSN Screening Tool and response with a corresponding LOINC code. This ensures Q/A pairs are properly categorized, organized, and accessed for retrieval from the QEs via the SHIN-NY Data Lake.

Screening Question and Response LOINC Codes are used for documenting HRSN Screening question and answer pairs.

Table 9-2: AHC HRSN Screening Tool[5] LOINC codes[6, 7]

OHIP AHC HRSN tool

SCREENING_PARENT_CODE	SCREENING_CODE_DESCRIPTION
NYSAHCHRSN	NYS AHC HRSN Screening tool

QUESTION	QUESTION_CODE	ANSWER_VALUE	ANSWER_CODE
1. What is your living situation today?*	71802-3	I have a steady place to live	LA31993-1
		I have a place to live today, but I am worried about losing it in the future	LA31994-9
		I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	LA31995-6
2. Think about the place you live. Do you have problems with any of the following? *	96778-6	**Pests such as bugs, ants, or mice**	LA31996-4
		Mold	LA28580-1
		Lead paint or pipes	LA31997-2
		Lack of heat	LA31998-0
		Oven or stove not working	LA31999-8
		Smoke detectors missing or not working	LA32000-4

5 The AHC HRSN Screening Tool https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
6 AHC HRSN Screening Tool https://loinc.org/96777-8
7 AHC HRSN supplemental questions https://loinc.org/97023-6 and https://loinc.org/100698-0

QUESTION	QUESTION_CODE	ANSWER_VALUE	ANSWER_CODE
		Water leaks	LA32001-2
		None of the above	LA9-3
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	96779-4	**Yes**	LA33-6
		No	LA32-8
		Already shut off	LA32002-0
4. Within the past 12 months, you worried that your food would run out before you got money to buy more	88122-7	**Often true**	LA28397-0
		Sometimes true	LA6729-3
		Never true	LA28398-8
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more	88123-5	**Often true**	LA28397-0
		Sometimes true	LA6729-3
		Never true	LA28398-8
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	93030-5	**Yes**	LA33-6
		No	LA32-8
7. Do you want help finding or keeping work or a job?	96780-2	**Yes, help finding work**	LA31981-6
		Yes, help keeping work	LA31982-4
		I do not need or want help	LA31983-2
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent	96782-8	**Yes**	LA33-6
		No	LA32-8
9. How often does anyone, including family and friends, physically hurt you?	95618-5	Never (1)	LA6270-8
		Rarely (2)	LA10066-1
		Sometimes (3)	LA10082-8
		Fairly often (4)	LA16644-9
		Frequently (5)	LA6482-9
10. How often does anyone, including family and friends, insult or talk down to you?	95617-7	Never (1)	LA6270-8
		Rarely (2)	LA10066-1
		Sometimes (3)	LA10082-8
		Fairly often (4)	LA16644-9

QUESTION	QUESTION_CODE	ANSWER_VALUE	ANSWER_CODE
		Frequently (5)	LA6482-9
11. How often does anyone, including family and friends, threaten you with harm?	95616-9	Never (1)	LA6270-8
		Rarely (2)	LA10066-1
		Sometimes (3)	LA10082-8
		Fairly often (4)	LA16644-9
		Frequently (5)	LA6482-9
12. How often does anyone, including family and friends, scream or curse at you?	95615-1	Never (1)	LA6270-8
		Rarely (2)	LA10066-1
		Sometimes (3)	LA10082-8
		Fairly often (4)	LA16644-9
		Frequently (5)	LA6482-9
Total Safety Score	95614-4	Sum question #9-12 above. **Score of 11 or more may indicate that a person may not be safe.**	

ANSWER_VALUES **bolded** may indicate a potential unmet need according to the CMS AHC HRSN tool.

iii. Screening in the SCN IT Platform

SCN Lead Entities and platform vendors should refer to Screening reimbursement requirements detailed in section 5.b.iv.

SCN LEs and their IT platform vendors should refer to the MVD and 1115 SHIN-NY FHIR IG for a comprehensive list of Screening data elements to configure their systems. Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to the live social care coding documents. Table 9-3 can be helpful to SCN Lead Entities and their SCN IT Platforms to see a snapshot of most Screening data elements in one place since the MVD does not offer this view. Table 9-3 is primarily a resource for Screening entities conducting Screens outside of an SCN IT Platform who do not have access to the MVD.

Note, for entities screening inside and outside the SCN IT platform the following is true: All Screening data elements are required for configuration. The required data elements on the NYeC website *(https://nyehealth.org/1115-waiver/)* must be completed in full during the Screening activity and are required for reimbursement. Collection of the other Screening Data elements (i.e., demographics, physical disability) is required for completion and must be initiated during the Screening activity but can be finished in future steps of the NYHER member journey if need be.

The SCN IT Platform will house HRSN Screening data for members who are screened by the SCN, including but not limited to:

a. *Member contact information*, member identifiers including name, address, phone number, and email (if available)
b. *Screener Identifiers*, unique Screening interaction identifiers assigned to a Screening entity type, including Screening entity ID and type
c. *Member's HRSNs across the six domains covered by the Screening Tool*. AHC HRSN Screening Tool questions and responses will be mapped using LOINC codes. LOINC codes will be mapped to reasonable ICD 10 CM and SNOMED codes following the assessment
d. *Whether the member is interested in receiving support for unmet HRSNs*
e. *Member consent for data sharing:* If a member declines to give consent for data-sharing:
    i. The Screening will end
    ii. The Screening will not be paid for by the SCN
f. *Individual who responded to Screening* (e.g., the member, parent, guardian or legally authorized representative) and that individual's relationship to the member. If this information cannot be tracked as part of Screening, it should be recorded in the member's Social Care Plan
    i. At the discretion of the SCN Lead Entity, any individual serving as the member's legally authorized representative may be required to provide documentation of their legal representation (court issued, etc.) regardless of the member's age. This documentation must be saved in the member's Social Care Plan
g. *Language in which Screening was conducted* and whether an interpreter was used
h. *Data about demographics and physical disability*
i. At the time of the Screening interaction, the Social Care Navigator should engage with the member to initiate gathering their responses on the following set of Demographic and Physical Disability questions built into the SCN IT Platform (based on OHIP's Minimum Viable Dataset)

Demographics

- Please reference the following resources for available response options: https://hl7.org/fhir/valueset-administrative-gender.html
- *What is the member's gender identity?*
    - Please reference the following resources for available response options: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1021.32/expansion
- *What is the member's preferred pronouns?*
    - Please reference the following resources for available response options: https://shinny.org/us/ny/hrsn/ValueSet-SHINNYPersonalPronounsVS.html
- *What is the member's sexual orientation?*
    - Please reference the following resources for available response options: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1240.11/expansion
- *What is the member's ethnicity?*
    - Please reference the following resources for available response options: https://hl7.org/fhir/us/core/STU3.1.1/StructureDefinition-us-core-ethnicity.html
- *What is the member's race?*
    - Please reference the following resources for available response options: https://hl7.org/fhir/us/core/STU3.1.1/StructureDefinition-us-core-race.html
- *What is the member's preferred language spoken?*

- Please reference the following resources for available response options: https://hl7.org/fhir/R4/valueset-languages.html

Physical Disability

- Please reference the following resources for available response options: http://shinny.org/us/ny/hrsn/Questionnaire/SHINNYDisablityQuestionnaire

- *Does the member have serious difficulty walking or climbing stairs (5 years old or older)?*
- *Does the member have difficulty dressing or bathing (5 years old or older)?*

iv. Screening conducted outside the SCN IT Platform

SCN Lead Entities and platform vendors should refer to Screening reimbursement requirements detailed in section 5.b.iv. Contracted Screening entities can be reimbursed to screen using the SCN's IT platform, a unique Screening IT platform, or Electronic Health Record Systems (EHRs) that is independent from the SCN IT Platform provided that the system used to conduct the Screening is 1115 SHIN-NY FHIR IG compliant. Inherent in this requirement is that system leverages the AHC Screening Tool or another assessment instrument with identical wording and LOINC coding as the AHC Tool for question-and-answer pairs. This allows data to be seamlessly integrated into the SCN IT Platform and ingested by the SHIN-NY.

For example, an ambulatory practice functioning as an SCN Screening entity may screen via their EHR, then contribute NYHER-compliant Screening data to their regional QE. This will allow data to flow to the SHIN-NY data lake and then out to the SCN IT Platform in the daily Screening data extract and/or via the real-time FHIR API, depending on SCN preference.

Screeners using platforms other than the SCN IT Platform to screen may receive payment for Screening if the Screening entity collects all Screening data elements outlined on the NYeC website *(https://nyehealth.org/1115-waiver/)* and is contracted with the SCN Lead Entity. Screening question data elements with an asterisk (Table 9-3 below) are required for reimbursement. See the Screening Methodology section, sub-section Reimbursement for Screenings, for more information.

All Screening data elements collected outside the SCN's IT platform should flow from said platform to the provider's regional QE to the SHIN-NY data lake to the SCN's IT platform.

Since the NYHER program requires the use of fast health care interoperability standards (FHIR) coding and exchange data standards, it remains agnostic to specific assessment instruments and IT platforms, if the standardized terminologies described in this guidance are implemented. This ensures the data utilized in the program is open source and accounts for the existing infrastructure that health and social care ecosystem partners already have in place.

If a member is screened for unmet HRSNs using a platform other than the SCN IT Platform, members will still need to provide consent for the sharing of Screening data (Screening Question 0) as part of the Screening in order for the SHIN-NY to share the Screening data with the SCN Lead Entity to proceed with the Eligibility Assessment.

Table 9-3: Select required data elements for Screenings conducted outside the SCN IT Platform

A comprehensive list of Screening data elements required for submission of the CSV or CCDA screens conducted outside the SCN IT Platform can be obtained from the NYeC website: see "Data Specification for Providers

Submitting Screenings via CSV or CCDA" linked on the NYeC website under "Data Specifications for Providers – View Data Specifications".

While all screeners are expected to ask all 12 questions, there may be scenarios when a member does not want to answer a particular question. In that scenario, questions #1-12 may be skipped and submitted without a response, and as best practice, should be assigned a DataAbsentReason code when transmitted to FHIR IG. Any DataAbsentReason code will be accepted, but it is recommended to use "Unknown". Refer to section 5. b. Screening iv. Screening Methodology for reimbursement requirements.

Item	Question	Response
Member Responses		
Question 0*	*We use this survey to understand needs our [members / patients / clients] have which could interfere with good health. We may share your answers with your other healthcare providers, and with your health plan and social services organizations, so they can determine if you qualify for any free non-medical services that could be helpful. Please check this box if you agree to continue. You can choose not to answer this survey, but we can only check for services if you do answer.*	Permit
		Deny
NYS AHC HRSN Tool	1. What is your living situation today?*	I have a steady place to live
		I have a place to live today, but I am worried about losing it in the future
		I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
	2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY*	Pests such as bugs, ants, or mice
		Mold
		Lead paint or pipes
		Lack of heat
		Oven or stove not working

Item	Question	Response
		Smoke detectors missing or not working
		Water leaks
		None of the above
	3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home*	Yes
		No
		Already shut off
	4. Within the past 12 months, you worried that your food would run out before you got money to buy more.*	Often true
		Sometimes true
		Never true
	5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.*	Often true
		Sometimes true
		Never true
	6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?*	Yes
		No
	7. Do you want help finding or keeping work or a job?*	Yes, help finding work
		Yes, help keeping work
		I do not need or want help
	8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.*	Yes
		No
	9. How often does anyone, including family and friends, physically hurt you?*	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	10. How often does anyone, including family and friends, insult or talk down to you?*	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)

Item	Question	Response
		Frequently (5)
	11. How often does anyone, including family and friends, threaten you with harm?*	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	12. How often does anyone, including family and friends, scream or curse at you?*	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	13. Safety Score	Sum of response values 9-12

v. Data Absent Reason Codes

1. Correctly submitted Screenings on the SCN IT Platform should include:
   a. All non-answers must be translated to a valid data absent reason code as shown in Table 9-4 below. Refer to section 5.b.v for question level guidance.
   b. NYeC / QE will not reject the Screening if another valid data absent reason code from Table 9-4 below is used.
   c. If a record is submitted that has a response that is not on the valid data absent reason code list in Table 9-4 below the record will reject.
2. Contracted entities utilizing off-platform screening tools should use data absent reason codes as a best practice but at this time will not be required.

Table 9-4: Data Absent Reason Codes

https://hl7.org/fhir/R4/valueset-data-absent-reason.html

Code	Display	Definition
unknown	Unknown	The value is expected to exist but is not known.
asked-unknown	Asked But Unknown	The source was asked but does not know the value.
temp-unknown	Temporarily Unknown	There is reason to expect (from the workflow) that the value may become known.

Code	Display	Definition
not-asked	Not Asked	The workflow didn't lead to this value being known.
asked-declined	Asked But Declined	The source was asked but declined to answer.
Masked	Masked	The information is not available due to security, privacy or related reasons.
not-applicable	Not Applicable	There is no proper value for this element (e.g. last menstrual period for a male).
Unsupported	Unsupported	The source system wasn't capable of supporting this element.
as-text	As Text	The content of the data is represented in the resource narrative.

For Direct Questioning by a Screener (Virtual, or In-Person)

For Screening questions #1-12, the Social Care Navigator may proceed with the Screening even if any of the questions are left blank. Blank responses should be transmitted to FHIR IG as any DataAbsentReason Code, recommended to be "Unknown".

For questions #9-12 only, related to Interpersonal Safety, a member can decline to answer, or a Social Care Navigator may decide not to ask the questions at their own discretion. See, Section 5 part viii. “Considerations for interpersonal safety questions asked during Screening” for additional Social Care Navigator support.

For Self-Administered Screenings (Website)

It is required that all questions are answered (with the exception of interpersonal safety) or a member will not be able to submit the Screening.

vi. Eligibility Assessment ICD-10 / SNOMED-CT Coding

All positive AHC HRSN Screening Tool responses will require further Eligibility Assessment. The coding required during the Eligibility Assessment can only be completed by manual data entry by the Social Care Navigator by selecting an appropriate ICD-10 and SNOMED-CT description of member’s unmet HRSN. The Eligibility Assessment finding provided by the Navigator will trigger accurate referral information.

If a member is screened and identified as having an unmet HRSN on any associated individual AHC HRSN Screening Tool question and during the Eligibility Assessment confirms their desire to accept the HRSN referral, a

corresponding ICD-10 Z code (social condition) and SNOMED-CT code (detailed findings associated with Enhanced HRSN service) will be used to map each identified need.

NOTE: "SNOMED-CT and ICD-10 Z codes will only be used upon a member's positive Screening result and confirmation of their unmet HRSN during the one-on-one Eligibility Assessment with the Social Care Navigator. The condition status should be confirmed during the Assessment."

Eligibility Assessment ICD-10 Z Codes and SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

For Direct Questioning During Eligibility Assessment (Virtual, or In-Person)

Every data field of the MVD integrated into the Eligibility Assessment must be answered by the member. The Social Care Navigator should conduct a comprehensive Eligibility Assessment informed by the member's identified needs from the HRSN Screening. The Social Care Navigator should answer all relevant questions. If a member's only positive Screening outcome was Interpersonal Safety, the Eligibility Assessment ICD10/SNOMED may be left blank.

vii. Social Care Plan: Person-Centered Goal Setting: SNOMED-CT

Social Care Plans are developed during Eligibility Assessments for members who belong to Enhanced Services Population(s). The Social Care Plan records member specific care considerations for delivery of HRSN services. The Social Care Plan is intended to be longitudinal and revisited as services are rendered and needs are met.

Person-Centered Goal Setting codes are available and encouraged to use in Year 1 but are not required to be used until Year 3.

The goals in the Social Care Plan are the intended objective(s) for the member to address their HRSNs. Goals may also be directly referenced in a referral by the Social Care Navigator (i.e., FHIR Service Request bundle with Goal, etc.). The following table outlines the SNOMED Code and the description to enable.

Person-Centered Goal Setting SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

viii. Navigation & Referrals: SNOMED-CT

Navigation services and referrals to Enhanced HRSN Services are sent upon completion of an Eligibility Assessment. The corresponding codes will cause a workflow to initiate referrals for relevant HRSN services. The SCN Lead Entity is responsible for developing a workflow to assign these referrals to a contracted community-based organization (CBO) within their network. The SCN's Social Care Navigator will have the capability to select the specific HRSN service provider from within their network for these referrals. It is imperative to meticulously document all services, including referrals, that are generated based on the SNOMED-CT and ICD-10 codes assigned during the Navigation and referral process.

Navigation population members are navigated to existing services to meet their HRSNs.

Navigation to HRSN related services: SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

Referral to Enhanced HRSN Services: Care Management SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

ix. Provision / Interventions HRSN Services: SNOMED-CT

The SCN IT Platform will record provision / interventions to address HRSN provided by the Social Care Network. The community organization that accepts the referral will provide the service to the member, will coordinate provision of the service with the member, and record its provision in the SCN IT Platform. SNOMED-CT codes will be assigned to the interventions recorded in the software and shared with the QE.

Intervention Codes for provision of HRSN services: SNOMED-CT: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

New York State has requested updates to the SNOMED-CT codes for HRSN services. SNOMED-CT and other standards organizations meet every month to review and adopt these proposed changes. Some of the changes requested by OHIP have already been scheduled for discussion and potential adoption, while others are still awaiting scheduling.

Proposed Intervention Codes for HRSN services: SNOMED-CT: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

To ensure that programmatic needs for referral specificity are met, NYS is currently working with its partners to seek creation and approval of new SNOMED CT codes. For those situations where referrals do not yet have a SNOMED CT, the SCN will be directed to use a NYS local code until official coding is released *(see anticipated publication dates below).*

x. Billing and Payment Protocol: HCPCS + Modifiers

The SCN IT Platform will generate a unique OHIP-defined HCPCS code and modifier that will be assigned to all the Enhanced HRSN services for billing purposes as a 1-to-1 coding option. The HRSN service provider who receives the referral via the SCN IT Platform will have the capability to mark the member's service as rendered. SCN Lead Entities will reimburse HRSN service providers in accordance with the OHIP approved HRSN Fee Schedule for Screening, Navigation, and Enhanced HRSN services delivered. In order for claims to process, the appropriate HCPCS code and associated modifier must be entered. Note: Modifiers **must** be entered in the same order as they appear below.

Billing and Payment: HCPCS and Modifiers: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to the live documents on NYeC's NYHER 1115 Extranet.

f. DATA AND SYSTEMS IMPLEMENTATION GUIDE (DSIG)

The NYHER Data and Systems Implementation Guide (DSIG) provides guidance on member enrollment and population identification, HRSN billing, claims, and data management guidance for the successful implementation of the NYHER Program. Specifically, the DSIG includes requirements around data transmission and the specific files that are exchanged between the SCN Lead Entities, their selected IT Platforms, NYeC, MCOs, QEs, and OHIP.

The DSIG should be referenced by technical staff of SCNs and MCOs involved in implementing and managing the NYHER program. Please note that two separate DSIGs are available, tailored to the primary audience: SCN Lead Entities or MCOs. The DSIGs can be accessed by SCN Lead Entities, MCOs, and SCN IT platform vendors on the NYHER 1115 Extranet site or the NYHER Systems Workgroup SharePoint site.

10. OHIP PRIVACY AND SECURITY REQUIREMENTS

OHIP privacy and security requirements sub-sections:

a. Introduction

b. Data Governance Framework

c. Data Privacy and Security

a. INTRODUCTION

The SCN Lead Entity's Data Governance is the collection of policies and procedures that standardize data management, advance interoperability, and ensure secure distribution of HRSN data. The importance of safeguarding sensitive information and ensuring regulatory compliance cannot be overstated. Data governance frameworks ensure that data collected, stored, and shared within the SCN Lead Entity and exchanged between the SCN Lead Entities and other stakeholders is handled responsibly and securely. Data governance provides the decision-making processes for the SCN Lead Entity governing body and its appointees to ensure that data is consistent, complete, interoperable, secure, discoverable, and trustworthy.

Data privacy and security controls and procedures are crucial for the SCN Lead Entity to protect sensitive member information from being misused or accessed by unauthorized people.

b. DATA GOVERNANCE FRAMEWORK

i. Data governance structure

The SCN Lead Entity shall establish decision-making processes for the network across institutional, administrative, and data governance. Institutional governance sets the framework for participation, leadership organization, priority setting, rulemaking, outcome evaluation, and conflict resolution. Administrative governance translates institutional policies into actionable plans, ensuring compliance, information sharing, and operational standards. Data governance involves implementing and enforcing these policies through meticulous data stewardship, including managing data collection, storage, exchange, and deletion. Effective governance ensures that all levels work cohesively to facilitate transparent and accountable decision-making processes.

ii. Data ownership

SCN Lead Entities shall own their data. However, SCN data may only be shared with approved entities for purposes of meeting SCN programmatic objectives and cannot be shared or used for commercial purposes. Data is derived or sourced from the Medicaid Program, and this may be provided by the Department directly or through the QEs / other third-parties. Each element of Medicaid Confidential Data (MCD) is confidential regardless of the document, mode of communication, or storage in which it is found. Data will not be considered "Medicaid Data" and owned by OHIP until it reaches New York State's Medicaid Data Warehouse (MDW). Health-Related Social Needs (HRSN) data generated through the SCN Lead Entity will be owned by the

originating entity until there is a disclosure and/or transmittal from the SHIN-NY to New York State's Medicaid program. Once HRSN data generated is transmitted to New York State's Medicaid program, the data will be considered owned and governed by OHIP.

iii. Data stewardship and oversight

The SCN Lead Entity shall establish data stewardship processes in compliance with the technical standards, data collection, management, storage, exchange, verification, validation, contestation, and deletion established by OHIP.

OHIP will conduct an internal risk-based evaluation of the SCN Lead Entity's technical and privacy standards through the DOH System Security Plan (SSP) v5 Critical Controls Attestation Form, System Overview, and through a Plan of Action and Milestones (POA&M) report. As detailed in section 10.c, OHIP will then employ a combination of attestations and independent third-party audits to confirm that required security and privacy controls are in place within the defined system boundary.

c. DATA PRIVACY AND SECURITY

i. Introduction

SCN Lead Entities' data privacy and security will be governed by New York State (NYS) Health IT regulations, NYS Department of Health Office of Health Insurance Programs Division of Operations and Systems (DOS) Security and Privacy Bureau requirements, and other applicable privacy and security federal and state laws and regulations.

Federal and state laws protect the confidentiality of Medicaid member data regardless of the document, mode of communication, or storage in which it is found. This data includes, but is not limited to, Protected Health Information (PHI) and Personally Identifiable Information (PII); however, it also includes the following:

- Names and addresses of Medicaid applicants/recipients
- Medical services provided
- Social and economic conditions or circumstances
- Department of Health evaluation of personal information
- Medical data, including diagnosis and history of disease or disability
- Income, eligibility information, and amount of Medicaid payments
- Information regarding the identification of third parties, and/or information the Department deems to be part of the operations of the Medicaid program that is of a sensitive nature, such as cost of services provided, and has repercussions if released

Collectively, OHIP refers to these data as Medicaid Confidential Data (MCD). To protect MCD, the Department has defined a Moderate-Plus Security Controls Baseline based on, and consistent with the security provisions described in Centers for Medicare and Medicaid Services (CMS) Acceptable Risk Safeguards (ARS) and National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53 at the Moderate level. Additionally, the Department has augmented these federal standards with New York State Policies and Standards.

Prior to OHIP permitting the release of Medicaid Confidential Data (MCD) to external organizations, those organizations shall demonstrate compliance with the Moderate-Plus Security and Privacy Controls Baseline to the Department's satisfaction.

As the SCN Lead Entity's digital maturity will evolve over time, it is understood that the SCN Lead Entity will systematically assess and strengthen its data privacy and security measures as necessary. The use of independent audits will ensure compliance with applicable federal and state privacy and security laws, regulations, and consensus adopted standards ISO 27001, NIST 800-53, SOC 1, and SOC 2 standards.

ii. Current State Security Assessment

After the contract was executed, the SCN Lead Entity met with New York State's Security and Privacy Bureau to assess the SCN Lead Entity's current state of security readiness and its IT systems.

OHIP aims to continue to guide SCN Lead Entities through a comprehensive process that will track security and privacy control adherence to ensure the proper protections are in place.

iii. Annual Privacy and Security Attestation and Audit

SCNs are required to submit annually the Medicaid Critical Controls Attestation which informs DOH of the SCN Lead Entity's current security and privacy posture. Periodic independent third-party audits are required. These third-party audits verify what was attested to in the Medicaid Critical Controls Attestation.

iv. Quarterly POA&M and Quarterly Names List (QNL) Requirements

The following activities must be completed and submitted on a quarterly basis by SCN Lead Entities to support ongoing oversight and compliance with the Medicaid Data Use Agreement (DUA) and privacy/security protocols: Plan of Action and Milestones (POA&M) and Quarterly Names List (QNL).

Plans of Action and Milestones (POA&M):

- Based on findings from the Medicaid Critical Controls Attestations and the third-party audits, SCN Lead Entities must take action to correct any deficiencies identified and add them to the SCN Lead Entity's POA&M report
- POA&Ms are required to be submitted to the Security and Privacy Bureau quarterly as well as with an annual attestation submission. The POA&M and annual attestation control status must match during the submission
- POA&Ms are due quarterly even if SCN Lead Entities do not have any updates
- Items should not be removed from the POA&M as it is a historical document. The SCN Lead Entity and OHIP will monitor progress of control implementation against the POA&M

Quarterly Names List (QNL):

- SCN Lead Entities must submit a QNL that documents the name of every individual who accesses Medicaid Confidential Data (MCD) – in any way – on the SCN Lead Entity's behalf. If vendors or contractors – including billing contractors – are performing any service, then the Requesting entity shall

include the names of these contractors on the QNL. Such activities may include running analytics or hosting data that results in MCD access.

QNL must include:

- First and last names
- MCD access start and end dates
- Email address (usernames are not required)
- Company name and address. This should be the company the person works for, not the SCN Lead Entity

Exclusions:

- Individuals from state agencies, DOH, and DOH Contractors should not be included on the names list
- Exception where the SCN has contracted directly with a third-party for services

v. Medicaid Critical Controls Attestation, System Overview, and Data Use Agreement

The SCN Lead Entity must complete and maintain the OHIP Medicaid Security plan. This plan consists of:

- Medicaid Critical Controls Attestation and system overview. The original deadline for this was **December 31, 2024,** and this is complete.
- **Third-Party Audit and Report** - Within one year from acceptance of the attestation the SCN will procure an independent third-party auditor to evaluate the controls to which the SCN has attested. This evaluation ensures the controls are implemented correctly, are operating as intended, and are producing the desired results for any system that is included in the system boundary. The auditor must produce a report for the Security and Privacy Bureau detailing the status of each critical control in the attestation. The SCN and auditor shall collaborate on the completion of the POA&M such that details of the deficiency are recorded along with proposed remediation dates for all controls that have not been fully implemented. **The annual attestation, audit report, and POA&M must be delivered to the Security and Privacy Bureau by December 31, 2025**. OHIP asks that SCN Lead Entities submit the annual attestation and third-party audit as early as possible in December to allow for processing time. OHIP requires the entire report generated by the SCN Lead Entity's auditor along with the submission of the POA&M. SCN Lead Entities should also submit updated System Overview if there are any changes to contact information, or other items, listed in the Overview.
- The SCN is responsible for ensuring that any vendors included in the system boundary meet the same controls attested to by the SCN. The SCN/independent auditor shall merge any vendor non-compliant controls into the report and POA&M.
- **Medicaid All Controls Attestation - By the end of both years 2026 and 2027**, the SCN shall submit an updated system overview and attestation to the Security and Privacy Bureau showing the status of each control, not only the critical controls, as they did in previous years. In other words, controls previously marked as OPTIONAL will now be required. The status of each control in the attestation shall match the status of each control listed in the POA&M.
- **Medicaid All Controls Attestation plus Audit – By the end of 2028**, the SCN shall obtain another independent third-party audit and submit an updated system overview and the annual attestation and audit report. The audit shall consist of all controls in the attestation
- **Future Cadence** - After 2028, the cadence of deliverables to the Security and Privacy Bureau will be an annual attestation each year, with an updated annual attestation and third-party independent audit in

the third year of the cadence. All audits must result in a report submitted to the Security and Privacy Bureau.

Table 10-1 below reflects the dates that documents will be due from the SCNs as described above and QNL and POA&M submission requirements.

Table 10-1: Due dates for documents to submit to Security and Privacy

Due Date	Document(s) to submit to Security and Privacy
12/31/2024	Initial critical control attestation (DONE).
12/31/2025	Annual critical control attestation, updated system overview, and third-party independent audit report.
12/31/2026	Annual attestation now including all controls plus updated system overview.
12/31/2027	Annual attestation of all controls plus updated system overview.
12/31/2028	Annual attestation, updated system overview, and 3rd party independent audit report of all controls.
12/31/2029	Annual attestation of all controls plus updated system overview.
12/31/2030	Annual attestation of all controls plus updated system overview.
12/31/2031	Annual attestation, system overview, and 3rd party independent audit report of all controls.
The 3-year cycle reflected above (years 2029 – 2031) will continue indefinitely.	

For which time period are you submitting a QNL and POA&M	Submission Due Date
Q1 - January to March	March 1st - 31st
Q2 - April to June	June 1st - 30th
Q3 - July to September	September 1st - 30th
Q4 - October to December	December 1st - 31st

Submission instructions: All Security and Privacy documentation should be emailed to doh.sm.Medicaid.Data.Exchange@health.ny.gov (Please email your submissions as early as possible within the month in which each is due.)

Reporting Possible Incidents/Events: SCNs must notify the Security and Privacy Bureau within one hour of the discovery of an actual or potential security/privacy event or incident. This notification should be made via email only and does not require a full incident report at that time. This aligns with the Data Use Agreement (DUA), Section 9, which states:

If DOH determines or believes that the Requestor has used, reused or disclosed MCD in a way other than as expressly authorized by this Agreement, DOH may require the Requestor to:

a. Promptly investigate and report to DOH the Requestor's determinations regarding any alleged or actual unauthorized use or disclosure;

b. Promptly resolve any problems identified by the investigation;
c. Submit a formal response to the allegation of unauthorized use, reuse or disclosure;
d. Submit a corrective action plan with steps designed to prevent any future unauthorized uses, reuses or disclosures; and
e. Destroy all data sets received from DOH and submit a Data Destruction Attestation

Additionally, the DUA requires that notification of any incident involving personally identifiable information (PII) or protected health information (PHI) must also include notifying any unauthorized recipients and affected individuals, without cost to DOH.

Offshore Access: The DUA prohibits offshore processing, storing, accessing, or transmitting MCD. Specifically, DUA Section 8: Offshore Prohibition states:
The Requestor agrees that any MCD provided under this Agreement shall not be accessed by employees, agents, representatives, or contractors/business associates who are located outside of the United States and its territories (offshore). Further, the Requestor agrees that MCD shall not be received, stored, processed, or disposed via information technology systems which are located offshore.

Environment Changes: SCNs may not move MCD from any part of an approved environment without first having a DUA Addendum making the environment change accepted by the Security and Privacy Bureau. Per DUA Section 6: Data Storage and Access:
When Requestor and Custodian take possession of MCD, it shall be stored in the location specified below. The data cannot be transferred by any means to another environment without a DUA Addendum to this Agreement that has been accepted by DOH.
Entities must notify OHIP and the Security and Privacy Bureau if they are considering an environment change, and they must go through the full approval process prior to making any change.

Environment Changes – Process

1. The entity notifies the Security and Privacy Bureau of an intent to modify the environment and submits an updated system overview document.
2. The Security team works with the entity to get the system overview and attestation accepted.
    a. Once accepted, the Privacy team provides a DUA addendum, which the entity completes to:
    b. Modify Section 6
3. Add the third party/downstream partner as a Business Associate by submitting and acknowledging a Business Associate Agreement (BAA).
4. Acceptance of this addendum serves as written permission for the entity to share MCD with the other party.

vi. Prohibited Uses

The following uses of SCN Data are prohibited:

- The sale of individually identifiable information (including but not limited to PHI and PII);
- The use of individually identifiable information for marketing purposes that would require an authorization under 45 C.F.R. § 164.508(a)(3); and
- Any purpose prohibited by applicable law

SCNs must develop breach response plans and promptly notify affected parties and regulatory agencies in the event of a PHI breach. The SCN must notify the Security and Privacy Bureau and the NYHER program of a possible event or security breach within 1 hour of identification of indicators of compromise. The Security and Privacy Bureau shall be notified at **doh.sm.Medicaid.Data.Exchange@health.ny.gov** and **IncidentReport@health.ny.gov.**

11. FEE SCHEDULE

Fee schedule sub-sections:

a. Screening

b. Care Management

c. Housing

d. Nutrition

e. Transportation

f. Appendix

SCNs have developed fee schedules for each region. The fee schedule information below applies statewide. Fee schedule updates go into effect 30 days post release or as otherwise indicated in the fee schedule.

a. SCREENING

Table 11-1: Fee Schedule - Screening

0. Screening	
Service Description	Screening conducted to assess member for health-related social needs. Each Medicaid member will receive a Screening annually or on an as-needed basis due to a major life event. See the SCN Operations Manual for a detailed list of major life events. To be reimbursed, Screening must include a 1:1 interaction between the Screener and member (interaction may be in-person, telephone, or other synchronous format). Reimbursement for Screening is time-based. Screening time includes time spent explaining the SCN program to a member, obtaining consent, walking the member through the Screening, inputting the member's information and answers to Screening questions, and responding to a member's questions about next steps. Entities will not receive payment if a member self-screens without a subsequent 1:1 interaction with a Screener or Social Care Navigator, including Screenings in which the member only uses an online self-screening tool or other digital Screening with no 1:1 interaction (e.g., online form, AI chatbot). All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Pricing Unit	Per 15-minutes
Unit Max	2 units per year (additional 2 units possible if major life event); max of 4 units per year
Duration	Entire Waiver period (through March 2027)

Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Screening – All Medicaid Member Screening	G0136	U8, U2
	Re-screening – All Medicaid Member Screening	G0136	UB, UA

b. CARE MANAGEMENT

Table 11-2: Fee Schedule - Navigation Services (Eligibility Assessment and Navigation)

1.1 Navigation Services (Eligibility Assessment and Navigation)	
Service Description	Eligibility Assessment and Navigation of FFS and non-eligible Medicaid Managed Care members to existing federal, state, and local benefits and programs. To be reimbursed, Navigation must include a 1:1 interaction between the Social Care Navigator and member during the Eligibility Assessment (interaction may be in-person, telephonic, or other synchronous format). Social Care Navigators may also bill for non-member facing time spent supporting the Eligibility Assessment and Navigation. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Pricing Unit	Per 15-minutes
Unit Max	8 units per year (additional 8 units possible if major life event); max of 16 units per year
Duration	Entire Waiver period (through March 2027)
Codes & Modifiers	Procedure codes: T1016 Modifiers: UB, U1

Table 11-3: Fee Schedule - Enhanced HRSN Care Management

1.2a Enhanced HRSN Care Management – Eligibility Assessment Level 2 Only **1.2b Enhanced HRSN Care Management – Care Management Level 2 Only**	
Service Description	Engagement by Social Care Navigator with Medicaid Managed Care (MMC) members that are part of an Enhanced Population eligible for Enhanced HRSN Services, including time spent on Eligibility Assessment, referral management, care coordination, coordination of select Enhanced HRSN Services, education, and follow-up to ensure member needs were met by services. Social Care Navigators may bill care management for coordination of the following services: 2.1 Home Accessibility and Safety Modifications, 2.2 Home Remediation Service, 2.3 Asthma Remediation, 2.4 Recuperative Care (Medical Respite), 2.5 Rent / Temporary Housing (Rental Subsidy and Back Rent), 2.6 Utility Setup / Assistance, 2.8 CTS, 3.5 Cooking Supplies, 4.1 Transportation

1.2a Enhanced HRSN Care Management – Eligibility Assessment Level 2 Only 1.2b Enhanced HRSN Care Management – Care Management Level 2 Only			
	To be reimbursed, Navigation must include a 1:1 interaction between the Social Care Navigator and member during the Eligibility Assessment (interaction may be in-person, telephonic, or other synchronous format). Social Care Navigators may also bill for non-member facing time spent supporting the Eligibility Assessment and Navigation. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement. Application fees: Covers application fees relevant to Enhanced HRSN Services (including Enhanced Care Management) to help support members to secure housing, transportation, employment, etc. Some examples include applying for a driver's license at DMV, background check fees, and housing application fees. For detailed service descriptions by service name/modifier, please refer to Appendix C of this document.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).		
Pricing Unit	Per 15-minutes Application Fees: Cost-based, up to capped amount per member		
Unit Max	20 units per month Application Fees: $100 for entire Waiver period (through March 2027)		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Enhanced Care Management – Eligibility Assessment Level 2 Only	T1016	U5, U3
	Enhanced Care Management – Care Management Level 2 Only	T2023	U9, U8
	Enhanced Care Management - Follow Up Level 2 Only	T2023	U9, U5
	Enhanced Care Management - Application Fees Level 2 Only	T2023	U9, U2

c. HOUSING

Table 11-4: Fee Schedule - Home Accessibility and Safety Modifications

2.1 Home Accessibility and Safety Modifications	
Service Description	Home Accessibility and Safety Modification services will consist of limited internal or external physical adaptations made to eligible member's home or community dwelling when necessary to ensure maximum health, welfare, and safety, or to allow the member to live independently in a community-based setting. The Home Accessibility and Safety Modifications service consists of the following elements:

2.1 Home Accessibility and Safety Modifications			
	• Dwelling Assessment & Statement of Work (SOW) Development • SOW Technical Review • Home Accessibility and Safety Modifications • Quality Assurance (QA) Inspection (if applicable) Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project. Adaptations are limited to: accessibility ramps, handrails, grab bars, electric door openers, widening of doorways, pathways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces. All installation services include general education on how to use and properly care for equipment, provided during installation. These services are available for a home that is owned, rented, leased, or occupied by the Medicaid member. OHIP will be monitoring distribution of spending across these services to ensure efficient and sustainable funding usage. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).		
Pricing Unit	Cost-based, up to cap		
Unit Max	Up to capped amount for Waiver period (inclusive of all services in 2.1 and 2.2: Home Accessibility and Safety Modifications, Mold and Pest Remediation, Ventilation Improving Systems, Equipment Provision)		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Dwelling Assessment - Modifications_Remediations Service	S5165	UA, U8
	SOW Technical Review – Modifications and Remediation Service	T2025	U2, UA
	Quality Assurance Inspection – Modifications and Remediation Service	T2025	U3, UA
	Home Accessibility and Safety Modifications – Accessibility Ramps	S5165	U3, UC
	Home Accessibility and Safety Modifications – Bathroom Facilities	S5165	U1, U4
	Home Accessibility and Safety Modifications – Doors and Cabinet Handles	S5165	U4, UB
	Home Accessibility and Safety Modifications – Electric Door Opener	S5165	U4, U9

2.1 Home Accessibility and Safety Modifications			
	Home Accessibility and Safety Modifications – Grab Bars	S5165	U5, UC
	Home Accessibility and Safety Modifications – Handrails	S5165	U4, UC
	Home Accessibility and Safety Modifications – Kitchen Cabinet or Sinks	S5165	U2, U4
	Home Accessibility and Safety Modifications – Non-skid Surfaces	S5165	U3, U4
	Home Accessibility and Safety Modifications – Pathways	S5165	U2, U8
	Home Accessibility and Safety Modifications – Widening Of Doorway	S5165	U8, U7

Table 11-5: Fee Schedule - Home Remediation Service: Mold and Pest Remediation

2.2a Home Remediation Service: Mold and Pest Remediation	
Service Description	Home Remediation services to promote member's health and wellbeing may include mold remediation (including fixing water leaks and removing damp or wet items to prevent mold growth) and pest remediation (including sealing / patching holes and cracks through which pests can enter the home). The Home Remediation: Mold and Pest Remediation service consists of the following elements: • Dwelling Assessment & Statement of Work (SOW) Development • SOW Technical Review • Home Remediation: Mold and Pest • Quality Assurance (QA) Inspection (if applicable) Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project. These services are available for a home that is owned, rented, leased or occupied by the Medicaid member. OHIP will be monitoring distribution of spending across these services to ensure efficient and sustainable funding usage. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Pricing Unit	Cost-based, up to cap

2.2a Home Remediation Service: Mold and Pest Remediation			
Unit Max	Up to capped amount per member (inclusive of all services in 2.1 and 2.2: Home Accessibility and Safety Modifications, Mold and Pest Remediation, Ventilation Improving Systems, Equipment Provision).		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Dwelling Assessment - Modifications_Remediations Service	S5165	UA, U8
	SOW Technical Review – Modifications and Remediation Service	T2025	U2, UA
	Quality Assurance Inspection – Modifications and Remediation Service	T2025	U3, UA
	Home Remediation: Mold and Pest	S5165	U7, UC

Table 11-6: Fee Schedule - Home Remediation Service: Ventilation Improving Systems

2.2b Home Remediation Service: Ventilation Improving Systems	
Service Description	Medically necessary improvement of ventilation systems. May include provision of devices and appliances that are eligible by clinical criteria (limited to air conditioner, air filtration devices, de-humidifier, humidifier and heater). The Home Remediation: Ventilation Improving Systems service consists of the following elements: • Dwelling Assessment & Statement of Work (SOW) Development • SOW Technical Review • Home Remediation: Ventilation Improving Systems • Quality Assurance (QA) Inspection (if applicable) Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project. These services are available for a home that is owned, rented, leased or occupied by the Medicaid member. OHIP will be monitoring distribution of spending across these services to ensure efficient and sustainable funding usage. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Pricing Unit	Cost-based, up to cap

2.2b Home Remediation Service: Ventilation Improving Systems			
Unit Max	Up to capped amount per member (inclusive of all services in 2.1 and 2.2: Home Accessibility and Safety Modifications, Mold and Pest Remediation, Ventilation Improving Systems, Equipment Provision)		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Dwelling Assessment - Modifications_Remediations Service	S5165	UA, U8
	SOW Technical Review – Modifications and Remediation Service	T2025	U2, UA
	Quality Assurance Inspection – Modifications Remediation Service	T2025	U3, UA
	Home Remediation – Air Conditioner	S5165	U8, UC
	Home Remediation – Air Filtration Devices	S5165	UA, UC
	Home Remediation – De-humidifier	S5165	U4, U7
	Home Remediation – Humidifier	S5165	U5, U4
	Home Remediation – Heater	S5165	U9, UC

Table 11-7: Fee Schedule - Home Remediation Service: Equipment Provision Systems

2.2c Home Remediation Service: Equipment Provision			
Service Description	Provision of medically necessary mini refrigeration units as needed for medical treatment and prevention (e.g., insulin). These services are available for a home that is owned, rented, leased or occupied by the Medicaid member. OHIP will be monitoring distribution of spending across these services to ensure efficient and sustainable funding usage. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).		
Pricing Unit	Cost-based, up to cap		
Unit Max	Up to capped amount per member (inclusive of all services in 2.1 and 2.2: Home Accessibility and Safety Modifications, Mold and Pest Remediation, Ventilation Improving Systems, Equipment Provision)		
Duration	Entire Waiver period (through March 2027)		
	Service Name	**Procedure Code**	**Modifiers**

Codes & Modifiers	Dwelling Assessment - Modifications_Remediations Service	S5165	UA, U8
	SOW Technical Review – Modifications and Remediation Service	T2025	U2, UA
	Quality Assurance Inspection – Modifications Remediation Service	T2025	U3, UA
	Home Remediation: Equipment Provision - Refrigeration Units	S5165	U6, U1

Table 11-8: Fee Schedule - Asthma Remediation: Asthma Self-Management Education (ASME)

2.3a Asthma Remediation: Asthma Self-Management Education (ASME)			
Service Description	Health education tailored to the needs of the member and family / caregivers to expand asthma knowledge. Content may include early warning signs and management of worsening symptoms, asthma control and medication adherence, and identification and reduction of asthma triggers. Initial visit must be conducted in-person or *virtually face-to-face in member's dwelling. Final visit may be conducted in-person in member's dwelling or face-to-face virtually (e.g., video call). In the rare circumstances where the member does not allow a face-to-face visit in-person or virtually, the final visit may be conducted telephonically. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).		
Pricing Unit	Per 15-minutes		
Unit Max	24 units for Waiver period		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Asthma Remediation - Self Management Education - (In-person or Virtual* Visit)	S9441	U6, U5
	Asthma Remediation - Self Management Education - (Telehealth/Teleconference)	S9441	U2, U3

Table 11-9: Fee Schedule - Asthma Remediation & Provision of Supportive Products

2.3b Asthma Remediation & Provision of Supportive Products	
Service Description	Provision of remedial services and supportive products to address ventilation and air quality, removal of asthma triggers, and Integrated Pest Management (IPM) in the member's home. Remediation services will be tailored to the individual needs of the member and the primary residence (owner-occupied or rental dwelling) of the member.

2.3b Asthma Remediation & Provision of Supportive Products			
	The Asthma Remediation & Provision of Supportive Products service consists of the following elements: • Dwelling Assessment & Statement of Work (SOW) Development • SOW Technical Review • Asthma Remediation & Provision of Supportive Products • Quality Assurance (QA) Inspection (if applicable) Both the HRSN service provider and contractors' coordination and administrative costs should be included in the SOW and should not exceed 10% of the total costs of the project. These services are available for a home that is owned, rented, leased or occupied by the Medicaid member. OHIP will be monitoring distribution of spending across these services to ensure efficient and sustainable funding usage. A detailed list of covered Asthma Remediation services and Supportive Products is provided in the Social Care Networks Operations Manual. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).		
Pricing Unit	Cost-based, up to cap		
Unit Max	Up to capped amount for Waiver period		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Dwelling Assessment – Asthma Remediation Service	S5165	U1,U2,U5
	SOW Technical Review – Asthma Remediation Service	T2025	U1,U2,U3
	Quality Assurance Inspection – Asthma Remediation Service	T2025	U1,U2,U4
	Asthma Remediation – Air conditioner	S5165	U6, U9
	Asthma Remediation – Air duct maintenance	S5165	UA, U4
	Asthma Remediation – Basement water proofing	S5165	U9, UA
	Asthma Remediation – Cleaning and installation of gutter screens and downspouts	S5165	UB, U2
	Asthma Remediation – Dirt floor vapor barrier	S5165	UB, U3
	Asthma Remediation – Dryer vent cleaning	S5165	U9, U7
	Asthma Remediation – Exhaust fans	S5165	U8, U4

2.3b Asthma Remediation & Provision of Supportive Products			
	Asthma Remediation – Forced air furnace and additional filters	S5165	U7, U3
	Asthma Remediation – Integrated Pest Management (IPM)	S5165	U8, U6
	Asthma Remediation – Repairing water damage	S5165	UB, U9
	Asthma Remediation – Carpet removal	S5165	UB, U8
	Asthma Remediation – Carpet steam cleaning	S5165	UB, U7
	Asthma Remediation – Whole house fan	S5165	UA, U2
	Asthma Remediation – Mold Remediation (≤10 sq. feet)	T2025	U5, UA
	Asthma Remediation – Mold Remediation (>10 sq feet)	T2025	U7, U5
	Asthma Remediation – Insulation and Air Sealing	T2025	U2, UB
	Asthma Remediation – Replacement of air filters in HVAC system	T2025	U5, UB
	Asthma Remediation – Heating unit clean and tune, repairs, or replacement	T2025	U3, U8
	Asthma Remediation – Sump pump repair or replacement	T2025	U3, U5
	Asthma Supportive Products – Asthma-friendly cleaning supplies	T2025	U6, U8
	Asthma Supportive Products – Indoor Allergen Reduction	T2025	U9, U6

Table 11-10: Fee Schedule - Recuperative Care (Medical Respite)

2.4 Recuperative Care (Medical Respite)	
Service Description	Temporary residential care and supportive services provided to homeless or unstably housed members who do not have an acute need to be hospitalized but require health care services and supports to continue to recover from an illness or prepare for a medical procedure. Services include short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. Service must be provided by NYS-certified Medical Respite Programs and in accordance with New York State's established Medical Respite regulations (10 NYCRR 1007) and program guidance. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement.

2.4 Recuperative Care (Medical Respite)	
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Pricing Unit	Per diem; SCNs can set individual provider rates within range provided. The range reflects different models of care and staffing intensity. OHIP expects that members will receive an appropriate level of care.
Unit Max	Post hospitalization stays up to 90 days once every 12 months (assessed on a rolling basis). Pre procedural care is limited to a clinically appropriate amount of time as determined by a medical professional but cannot exceed 30 days per year.
Duration	Entire Waiver period (through March 2027)
Codes & Modifiers	Procedure codes: S9125 Rate code: 7980

Table 11-11: Fee Schedule - Rent and Temporary Housing (Rental Subsidy and Back Rent)

2.5 Rent and Temporary Housing (Rental Subsidy and Back Rent)			
Service Description	Rent / Temporary Housing (Rental Subsidy and Back Rent) includes payment for rent for up to six months. Rental subsidy and back rent may be used for a) Permanent / Long Term Housing or b) Temporary / Transitional Housing. All additional requirements defined in the Social Care Networks Operations Manual must be met in order to qualify for reimbursement. Modifiers are used to identify the unit size of the rental property / temporary housing. Social Care Navigators determine the appropriate unit size during the Eligibility Assessment based on the number of members in the household (See Operations Manual for additional guidance). OHIP will monitor service expenditure to ensure that the unit size is appropriate for the household size.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).		
Pricing Unit	Per unit per month based on assigned unit size; cost-based, up to cap. Note: Updated caps apply to services that are initiated on or after the Fee Schedule effective date.		
Unit Max	Limited to 6 months for the Waiver period (inclusive of back rent and prospective payments)		
Duration	Up to 6 months		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Rent and Temporary Housing – Studio	H0044	U4, U1
	Rent and Temporary Housing – 1 Bedroom	H0044	U4, U3
	Rent and Temporary Housing – 2 Bedroom	H0044	U4, U5

2.5 Rent and Temporary Housing (Rental Subsidy and Back Rent)			
	Rent and Temporary Housing – 3 Bedroom	H0044	U2, U9
	Rent and Temporary Housing – 4 Bedroom	H0044	U3, U9

Table 11-12: Fee Schedule - Utility Setup - Activation Expenses

2.6a Utility Setup - Activation Expenses	
Service Description	Provides payment for non-refundable, non-recurring utility set-up costs or restart costs if the service has been discontinued This service will cover expenses for the following types of utility payments: gas/oil, electric, water, sewage, garbage, recycling, internet and phone (inclusive of landline and cell phone). Available only to members receiving 2.5 Rent and Temporary Housing (Rental Subsidy and Back Rent) services. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).
Pricing Unit	Cost-based, up to cap
Unit Max	One time, up to capped amount for Waiver period
Duration	Entire Waiver period (through March 2027)
Codes & Modifiers	Procedure codes: T2025 Modifiers: UC, U3

Table 11-13: Fee Schedule - Utility Setup - Back Payments

2.6b Utility Setup - Back Payments	
Service Description	Covers costs of back payments to secure and maintain utility service. This service will cover expenses for the following types of utility payments: gas/oil, electric, water, sewage, garbage, recycling, internet and phone (inclusive of landline and cell phone). Available only to members receiving 2.5 Rent and Temporary Housing (Rental Subsidy and Back Rent) services. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).
Pricing Unit	Cost-based, up to cap

2.6b Utility Setup - Back Payments	
Unit Max	One time, up to capped amount for Waiver period
Duration	Entire Waiver period (through March 2027)
Codes & Modifiers	Procedure codes: T2025 Modifiers: UC, U4

Table 11-14: Fee Schedule - Utility Assistance

2.6c Utility Assistance	
Service Description	Covers recurring monthly utility costs. This service will cover expenses for the following types of utility payments: gas/oil, electric, water, sewage, garbage, recycling, internet and phone (inclusive of landline and cell phone). Available only to members receiving 2.5 Rent and Temporary Housing (Rental Subsidy and Back Rent) services. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).
Pricing Unit	Cost-based, up to cap per month
Unit Max	Up to 6 months, with capped amount per month
Duration	Entire Waiver period (through March 2027)
Codes & Modifiers	Procedure codes: H0044 Modifiers: UB, UC

Table 11-15: Fee Schedule - Pre-Tenancy Services

2.7 Pre-Tenancy Services	
Service Description	Services to assist with navigating the complexities of the housing search and application process when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews. This also includes assistance with search for rentals and contacting apartments. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).
Pricing Unit	Per 15-minutes
Unit Max	24 units over 6 months
Duration	Up to 6 months for Waiver period

2.7 Pre-Tenancy Services			
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Pre-Tenancy Services - Navigating and Completing Housing Application	T2025	UC, UA
	Pre-Tenancy Services - Negotiating Lease Agreements	T2040	UC, U8
	Pre-Tenancy Services -Tenant Screening Assistance and Tenant Interviews	T2025	UC, U7

Table 11-16: Fee Schedule - Community Transitional Supports

2.8a Community Transitional Supports	
Service Description	Assistance to members who have secured a new housing unit to have a smooth and seamless transition to community living. Includes assistance with the set-up of the new housing unit and review of the living environment to ensure that it meets the member's clinical, furnishings, adaptive aids, environmental modifications, and food and clothing needs at transition. The following one-time transition and moving costs are included: 1. Security deposit; 2. Utility activation fees, movers, and relocation expenses; 3. Pest eradication and inspection fees; 4. Pantry stocking food (limited to a maximum of 30 days of food); and 5. The purchase of household goods and furniture. Covered furnishings are limited to: a. **Living Room:** Couch/ loveseat/ recliner; table lamp b. **Kitchen:** Table and chairs; Countertop microwave; Garbage pail; Kitchen kit: pots, pans, utensils, dishes, dish soap, dishtowels; Coffee pot; Toaster (not oven) c. **Bathroom:** Bathroom kit: bath towels, wash cloths, hand towels, mats for floor and bathtub, basic toiletries including toothbrush, hairbrush or comb, and initial purchase of soap, shampoo, conditioner, toothpaste, and toilet paper; toilet plunger; tension rod; shower curtain, liner, and rings; grab bar; handheld shower head d. **Other:** Secure medicine storage container; vacuum under $100; essential cleaning supplies; clock; blinds/ curtains; foldable shopping cart e. **Bedroom (per participant):** Sheets and pillows; waterproof/vinyl mattress and pillow protector; bed (mattress, box spring, and frame; twin or full size); comforter; chest of drawers; nightstand; lamp It is the responsibility of the HRSN service provider to obtain receipts for all items purchased. Copies of receipts must be submitted to the SCN Lead Entity.

2.8a Community Transitional Supports			
	Modifiers are used to identify the unit size of the property associated with CTS services. Social Care Navigators determine the appropriate unit size during the Eligibility Assessment based on the number of members in the household (See Operations Manual for additional guidance). OHIP will monitor service expenditure to ensure that the unit size is appropriate for the household size. Note: Coverage of broker's fees is limited to Long Island region.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).		
Pricing Unit	Cost-based, up to cap based on assigned unit size. Note: Updated caps apply to services that are initiated on or after the Fee Schedule effective date.		
Unit Max	Up to capped amount based on assigned unit size, may be used in increments without exceeding cap if member is eligible. Service does not continue after the individual is stably housed.		
Duration	Entire Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Community Transitional Supports - Studio	T2025	U4, U1
	Community Transitional Supports – 1-Bedroom	T2025	U4, U3
	Community Transitional Supports – 2-Bedroom	T2025	U4, U5
	Community Transitional Supports – 3-Bedroom	T2025	U2, U9
	Community Transitional Supports – 4-Bedroom	T2025	U3, U9

Table 11-17: Fee Schedule - Community Transitional Services - Broker's Fee

2.8b Community Transitional Services - Broker's Fee	
Service Description	One-time transition cost to cover broker's fees for housing as part of CTS services. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Service Delivery	Allowed one time during Waiver period for qualified members in ~~Manhattan, Bronx, Brooklyn, Queens, Staten Island, and~~ Long Island. SCNs are accountable to manage their spend against their SCN-level caps for CTS Broker's Fee. SCNs will be financially accountable for services delivered over and above SCN-level caps. OHIP will ask Lead Entities to report spend against each SCN-level cap for CTS Broker's Fee; OHIP will also monitor spending via social care claims.

2.8b Community Transitional Services - Broker's Fee	
Pricing Unit	Cost-based, SCN-level cap (Jan 1, 2025 – Mar 31, 2027~~6~~)
Unit Max	N/A
Setting	N/A
Duration	Once during Waiver period (through March 2027)
Codes & Modifiers	Procedure codes: T2025 Modifiers: U4, U2

Table 11-18: Fee Schedule - Tenancy Sustaining Services

2.9 Tenancy Sustaining Services	
Service Description	Services to assist in maintaining and sustaining member tenancy in affordable or supportive housing by providing tenant rights education and eviction prevention. Tenancy Sustaining Services are intended to assist members in securing housing and have a smooth and seamless transition to community living. These services can include: • Assistance in linking to free or affordable legal services for members facing housing-related issues; • Connection to available resources to assist in establishing a bank account and paying bills; • Assistance in connecting the member with social services to assist with filling out applications and appropriate documentation to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy; • Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include direct interventions to address risks and connecting the member to relevant community resources that may offer assistance; • Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions • Assistance with housing recertification processes, including lease renewals and housing subsidy renewals • Assistance with housing and utilities coordination services (e.g., coordination of back payments) All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I).
Pricing Unit	Per 15-minutes
Unit Max	24 units over 6 months
Duration	Up to 6 months

2.9 Tenancy Sustaining Services			
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Tenancy Sustaining Services - Rights, Education, Eviction Prevention, Dispute Resolution, Risk Intervention, and Legal Services	T2040	UC, UB
	Tenancy Sustaining Services - Financial Education, Literacy and Resources	T2040	U1, UC
	Tenancy Sustaining Services - Housing Recertification and Renewals	T2040	U2, UC

Table 11-19: Fee Schedule - Housing Transition and Navigation

2.10 Housing Transition and Navigation	
Service Description	Services to assist with an eligible member's transition into a new home, including: • Assisting with the set-up of the new housing unit, including coordinating clinically appropriate residential modifications and arranging the move • Connecting member to resources aiding with housing costs and other expenses; including linkages to rental assistance vouchers, security deposits, application fees, moving costs, etc. • Reviewing the living environment to ensure that it meets the clinical needs of the individual and is ready for move-in, including collaborating with the relevant provider staff where the individual is institutionalized (e.g., hospital or facility social worker) to ensure a seamless transition to the community All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).
Pricing Unit	Per 15-minutes
Unit Max	16 units per month for up to 6 months, may be re-authorized up to 6 months per re-authorization, up to the duration of the waiver demonstration period as long as the member has an unmet need and is eligible to receive services
Duration	Entire Waiver demonstration period (through March 2027)
Codes & Modifiers	Procedure code: H0043 Modifiers: UA, U5

d. NUTRITION

Table 11-20: Fee Schedule - Nutrition Counseling & Education

3.1 Nutrition Counseling & Education			
Service Description	Nutrition counseling and education services, covering topics on healthy meal preparation and connecting members with grocery budget resources. Service should be delivered by a Certified Dietitian / Nutritionist (CDN) or Registered Dietician Nutritionist (RDN) and can be conducted in individual or group settings. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).		
Pricing Unit	Per 15-minutes (Individual); Per 30-minutes (Group)		
Unit Max	Up to 8 15-minute units; or 4 30-minute units; or a combination of 15- and 30-minute units totaling 2 hours, up to 6 months total.		
Duration	Up to 6 months with possibility of re-authorization, up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Nutritional Counseling and Education-Counseling and Education: Individual (Initial assessment)	97802	U6, U2
	Nutritional Counseling and Education-Counseling and Education: Individual (Re-assessment)	97803	U6, U3
	Nutritional Counseling and Education-Counseling and Education: Group (2 or more individuals)	97804	U7, UA

Table 11-21: Fee Schedule - Medically Tailored Meals and Clinically Appropriate Home Delivered Meals

3.2a Medically Tailored Meals and 3.2b Clinically Appropriate Home Delivered Meals	
Service Description	**Medically tailored meals** are designed to be tailored by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) to an individual member with a chronic condition and/or pregnant or post-partum persons and must adhere to standards informed by established nutrition guidelines, such as the Food is Medicine (FIMC) MTM nutrition standards, for specific health conditions. **Clinically appropriate meals** must provide well-balanced, nutritionally appropriate meals that adhere to evidence-based nutritional guidelines. Clinically appropriate meals promote health and wellness for enhanced populations who have an unmet HRSN under the food domain and meet the USDA definition of low food security but do not have chronic conditions and are not pregnant/postpartum persons. All meals provided must be approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) and must adhere to standards informed by appropriate nutrition guidelines.

3.2a Medically Tailored Meals and 3.2b Clinically Appropriate Home Delivered Meals			
	Members who receive home delivered medically tailored or clinically appropriate meals cannot also receive 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions or 3.4 Fresh Produce and Non-perishable Groceries (Pantry Stocking). HRSN service providers may charge for food, delivery, and administrative costs associated with each member's services. Costs associated with the initial intake / assessment and meal plan design may be billed under the reimbursement range. SCN Lead Entities should monitor HRSN service providers' costs within the reimbursement range to ensure program efficiency. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I). Members can participate in federally funded programs and still be eligible for HRSN nutrition services if they meet HRSN nutrition service eligibility criteria.		
Pricing Unit	Per meal; cost-based, within range		
Unit Max	This service is limited up to three (3) prepared meals a day, seven days a week. Meal services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services		
Duration	Meal services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Clinically Appropriate Meals	S5170	U6, U4
	Clinically Appropriate Meals (HOUSEHOLD)	S5170	U6, U4, TT
	Medically Tailored Meals (MTM)	S5170	U6, U7
	Medically Tailored Meals (MTM) (HOUSEHOLD)	S5170	U6, U7, TT

Table 11-22: Fee Schedule - Medically Tailored or Nutritionally Appropriate Food Prescriptions

3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions			
Service Description	Food prescriptions (dairy, produce, meat, grains and spices) in the form of nutrition vouchers, coupons, or food boxes. Vouchers and coupons may only be redeemed at food pharmacies, food pantries, grocery stores, farmer's markets, mobile markets, and Community Supported Agriculture (CSA) subscriptions. Members who opt for food boxes will receive a weekly delivery of food appropriate for preparing weekly meals. Meals can only be delivered to the enrolled member's home or private residence. Members who receive food prescriptions cannot also receive 3.2 Medically Tailored Meals or Clinically Appropriate Home Delivered Meals, or 3.4 Fresh Produce and Non-perishable Groceries (Pantry Stocking). HRSN service providers may charge for food, delivery, and administrative costs associated with each member's services. Costs associated with the initial intake / assessment and meal plan design may be billed under the reimbursement range. SCN Lead Entities should monitor HRSN service providers' costs within the reimbursement range to ensure program efficiency. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.I). Members can participate in federally funded programs (SNAP or WIC) and still be eligible for HRSN nutrition services if they meet HRSN nutrition service eligibility criteria		
Pricing Unit	Per week; cost-based, within range		
Unit Max	This service is limited to up to three (3) prepared meals a day, seven days a week. Food prescription services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services		
Duration	Food prescription services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Medically Tailored or Nutritionally Appropriate Food Prescriptions – Boxes	T2025	U3, U2

3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions			
	Medically Tailored or Nutritionally Appropriate Food Prescriptions – Boxes (HOUSEHOLD)	T2025	U3, U2, TT
	Medically Tailored or Nutritionally Appropriate Food Prescriptions – Voucher	T2025	U5, U1
	Medically Tailored or Nutritionally Appropriate Food Prescriptions – Voucher (HOUSEHOLD)	T2025	U5, U1, TT

Table 11-23: Fee Schedule - Fresh Produce and Non-Perishable Groceries (Pantry Stocking)

3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	
Service Description	Pantry stocking of fresh produce and nonperishable groceries (excludes perishable meat and dairy products) furnished via pick-up or delivery. Fresh Produce and non-perishable groceries will serve to nutritionally supplement up to 3 meals/day, 7 days/week. Members who receive this service cannot also receive 3.2 Medically Tailored Meals or Clinically Appropriate Home Delivered Meals or 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions. HRSN service providers may charge for food, delivery, and administrative costs associated with each member's services. Costs associated with the initial intake / assessment and meal plan design may be billed under the reimbursement range. SCN Lead Entities should monitor HRSN service providers' costs within the reimbursement range to ensure program efficiency. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l). Members can participate in federally funded programs (SNAP or WIC) and still be eligible for HRSN nutrition services if they meet HRSN nutrition service eligibility criteria.
Pricing Unit	Per week; cost-based, within range
Unit Max	Pantry stocking services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services

3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)			
Duration	Pantry stocking services are provided for: • Pregnant/postpartum individuals: throughout their pregnancy and up to 12 months postpartum • Other eligible individuals: up to 6 months at a time, can be re-authorized one-time for up to 6 additional months as long as the member has an unmet need and is eligible to receive services		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	T2025	U2, U6
	Fresh Produce and Non-Perishable Groceries (Pantry Stocking) (HOUSEHOLD)	T2025	U2, U6, TT

Table 11-24: Fee Schedule - Cooking Supplies

3.5 Cooking Supplies	
Service Description	Cooking supplies that are necessary for meal preparation and nutritional welfare for a member when not available through other programs, including kitchenware, microwave, and full-size refrigerator (independent of medical mini refrigerator available under Home Remediation Service 2.2c). Social Care Navigators are strongly encouraged to spend no more than $600 per refrigerator. Kitchenware may include (but are not limited to) the following items: plates, bowls, cooking utensils, mixing bowls, pots and pans, chef's knife, cutting board, eating utensils, silverware, glassware, can opener, colander. Note: Small appliances to support meal preparation and nutritional welfare (e.g., food blender) are allowed. Appliances beyond microwave and full-size refrigerator are not covered. For HRSN service providers that are not Social Care Navigators, time spent coordinating the purchase of a member's cooking supplies may be billed under the Cooking Supplies service. HRSN service providers' coordination costs are capped at 5% of the cost of each member's cooking supplies. All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement.
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).
Pricing Unit	Cost-based, SCN-level cap (Jan 1, 2025 – Mar 31, 2027~~6~~) and member-level cap

3.5 Cooking Supplies			
Unit Max	N/A		
Duration	One time during Waiver period (through March 2027)		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifiers**
	Cooking Supplies - Kitchenware	T2025	UA, U6
	Cooking Supplies - Microwave	T2025	U9, U1
	Cooking Supplies - Refrigerator	T2025	U6, UB

e. TRANSPORTATION

Table 11-25: Fee Schedule - Transportation Services: Public & Private

4.1 Transportation Services: Public & Private	
Service Description	Provision of Medicaid member-occupied public or private transportation services to Enhanced HRSN Services to which they have been referred or other HRSN-related activities. Transportation services may include taxi/livery, rideshare/Transportation network company (TNC), or public transportation. Transportation planning can be billed for by the member's Social Care Navigator under Enhanced Care Management or may be conducted by the HRSN service provider and billed under the Transportation service. Transportation providers using volunteer drivers should not bill SCN Lead Entities for volunteers' time spent transporting members but may bill for other costs associated with providing HRSN Transportation services (e.g., gas). Family members of a member receiving Transportation services cannot provide transportation to the member as a volunteer driver for a Transportation service provider. **Detailed Service Descriptors by Modifier** • Private (T2025, U4, U6) or Public (T2025, U3, U6) Transportation to Enhanced HRSN Care Management : Reimbursement for private or public transportation to connect member to care management activities listed above in Section 1.2b • Private (T2025, U7, U6) or Public (T2025, U5, U6) Transportation to HRSN Services Only : Reimbursement for private or public transportation to connect member to HRSN services, such as: • Housing appointments; • Housing court (eviction prevention); • Local Department of Social Services / Vital Records appointments; • Local Department of Motor Vehicles appointments; • Education and support for chronic conditions; • Court, probation, parole, and order of protection-related appointments; • Childcare / Parenting classes; and Transportation to food pharmacies, farmer's markets, mobile markets.

4.1 Transportation Services: Public & Private			
	All additional requirements in Social Care Networks Operations Manual must be met in order to qualify for reimbursement. Note on Congestion Pricing: **NYHER funds cannot be used to pay congestion tolls under any circumstances.** SCN Lead Entities and contracted transportation providers should follow the guidance outlined in the SCN Operations Manual and Appendix D in the fee schedule, which will be in effect as of 10/1/2025.		
Eligibility	Refer to *Social Care Networks Operations Manual* for the latest eligibility criteria (including guidance on duplicative services in Section 5.l).		
Pricing Unit	Cost-based, SCN-level cap (Jan 1, 2025 – Mar 31, 2027~~6~~)		
Unit Max	N/A		
Duration	Up to 6 months with possibility of re-authorization, up to 6 months per re-authorization, up to the duration of the Waiver as long as the member has an unmet need and is eligible to receive services		
Codes & Modifiers	**Service Name**	**Procedure Code**	**Modifier**
	Private Transportation - Care Management	T2025	U4, U6
	Private Transportation - HRSN Services Only	T2025	U7, U6
	Public Transportation - Care Management	T2025	U3, U6
	Public Transportation - HRSN Services Only	T2025	U5, U6
	SCN Congestion Toll	A0110	TJ

f. APPENDIX

Table 11-26: Billing guidelines for timed codes

For any timed code measured in 15-minute units, providers may bill a single 15-minute unit for service duration greater than or equal to 8 minutes through and including 22 minutes. Time intervals for 1 through 8 units are as follows:

Units	Lower bound (min.)	Upper bound (min.)
1	≥ 8	22
2	≥ 23	37
3	≥ 38	52
4	≥ 53	67
5	≥ 68	82
6	≥ 83	97
7	≥ 98	112
8	≥ 113	127

Table 11-27: Detailed Service Descriptors by Modifier for Section 1.2 Enhanced HRSN Care Management Codes

Service Name	Service Description	Procedure Code	Modifiers
Enhanced Care Management – Eligibility Assessment Level 2 Only	Utilized for members who are assessed to meet the criteria of an Enhanced Population, only	T1016	U5, U3
Enhanced Care Management – Care Management Level 2 Only	Used for navigation/referral to enhanced services, service coordination, and connection to non-NYHER funded services	T2023	U9, U8
Enhanced Care Management – Follow Up Level 2 Only	1:1 follow-up with member after initial connection to services and/or linkage to HRSN service provider	T2023	U9, U5
Enhanced Care Management – Application Fees Level 2 Only	Covers application fees to assist members in securing essential services such as housing, transportation, employment, etc. Examples of covered costs include costs associated with obtaining copies of vital records (i.e. birth certificate), obtaining non-driver identification, driver's license application fees at the DMV, background check fees, and housing application fees	T2023	U9, U2