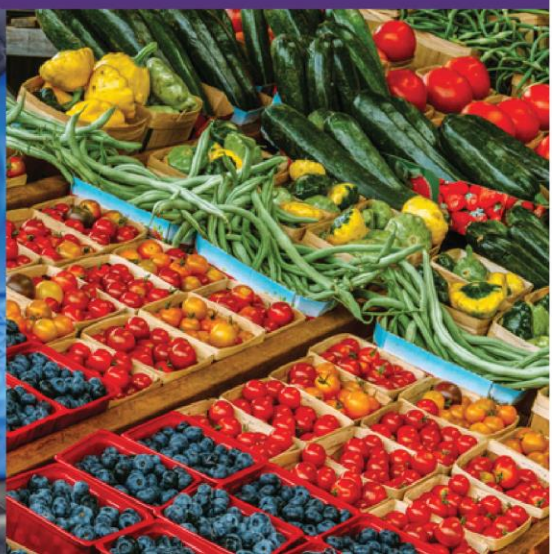
NEW YORK STATE | Department of Health

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



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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
	Monthly Performance Management Report (Horizon Reports)
	Governing Body Report
	Network Composition Plan and Report
	Infrastructure Cost Report
	Budget Reassessment Report
SCN resources	Member Fair Hearing Rights and Process
	SCN Instructions Manual for Monthly Horizon Reports
	SCN Performance Improvement Plan

1. GLOSSARY OF COMMON TERMS

Term	Definition and term details
Accountable Health Communities (AHC) Health-Related Social Need (HRSN) Screening Tool	Standard 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. CBOs may contract with SCN Lead Entities to become part of a Social Care Network (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*)
Detailed Business Requirements (DBRs)	Comprehensive definitions of metrics contained in performance management reports, including intended outcomes of tracking the metric, specific inputs / calculations required to measure those outcomes (e.g., numerators, denominators), and key assumptions related to each metric
Ecosystem partners	Entities not contracted into the SCN but that may collaborate with the SCN, including but not limited to MCOs, local agencies / departments, and healthcare 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*)
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
ePACES	Electronic Provider Assisted Claim Entry System, a web-based application which will allows providers to create / submit claims and other transactions (e.g., Eligibility check and Prior Approval) in HIPAA format. eMedNY developed this application on behalf of the NYS Department of Health
Healthcare provider	Entities providing health care to individuals, including Medicaid members. Healthcare providers include providers of behavioral health, primary care, as well as all areas of health care services.
Homeless	As defined by U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, 4 categories of homelessness:

Term	Definition and term details
	○ Literally homeless ○ Imminent risk of homelessness ○ Homelessness under other Federal regulations ○ Fleeing / attempting to flee domestic violence (*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
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, healthcare providers, for-profit organizations, etc.) (*See Roles and responsibilities of entities within the Social Care Network and broader ecosystem for more information*)
Major Life Event	Permanent or fluctuating event in a Member's life that makes a Member eligible for reimbursed HRSN re-screening. 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
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*)

Term	Definition and term details
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. 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 for which there is evidence that a specific HRSN service can improve their health
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 healthcare 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)*
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
SCN Lead Entity	Entity responsible for coordinating the Network of HRSN service providers and healthcare 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 Accountable Health Communities (AHC) screening tool to assess Member HRSNs related to housing and utilities, food security, transportation, employment, education, and interpersonal safety

Term	Definition and term details
	(*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 healthcare professionals statewide. In partnership with New York State, New York eHealth Collaborative (NYeC) developed and manages the technology platform that connects New York's Qualified Entities (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, healthcare 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*)
Social Care Navigation (also called Navigation)	Process by which eligible MMC Members are referred to the appropriate HRSN service providers and FFS and other MMC Members are navigated to existing federal, state, or local resources *(See Social Care Navigation for more information*)
Social Care Navigator (also called Navigator)	Refers eligible MMC Members to the appropriate HRSN service providers and navigates FFS and other MMC Members to existing federal, state, or local resources. Must have access to the SCN IT Platform *(See Social Care Navigation 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 positive unmet need response from the Member's screening results, the Social Care Navigator must assess the related Social Risk Factor. Criteria is located within the Enhanced Services Member File (*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 Social Care Network (SCN) Lead Entities designated by OHIP.

This includes requirements governing the delivery of HRSNs services to New York's Medicaid Fee-For-Service (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 healthcare 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 Community Based Organizations (CBOs) and other HRSN service providers, Managed Care Organizations (MCOs), and healthcare providers (inclusive of behavioral health and primary care providers).

3. INTRODUCTION

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 Social Care Networks (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 Community Based Organizations and other organizations providing HRSN services as well as healthcare 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:

1. Enable consistent, timely screening using the AHC HRSN Screening Tool and Navigation to HRSN services
2. Create shared end-to-end visibility of the Member journey from HRSN Screening and Navigation through delivery of HRSN services
3. Expand access to high-quality HRSN services
4. 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 Community Based Organizations.

b. OVERVIEW OF SCN PROGRAM DESIGN

i. Core 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:

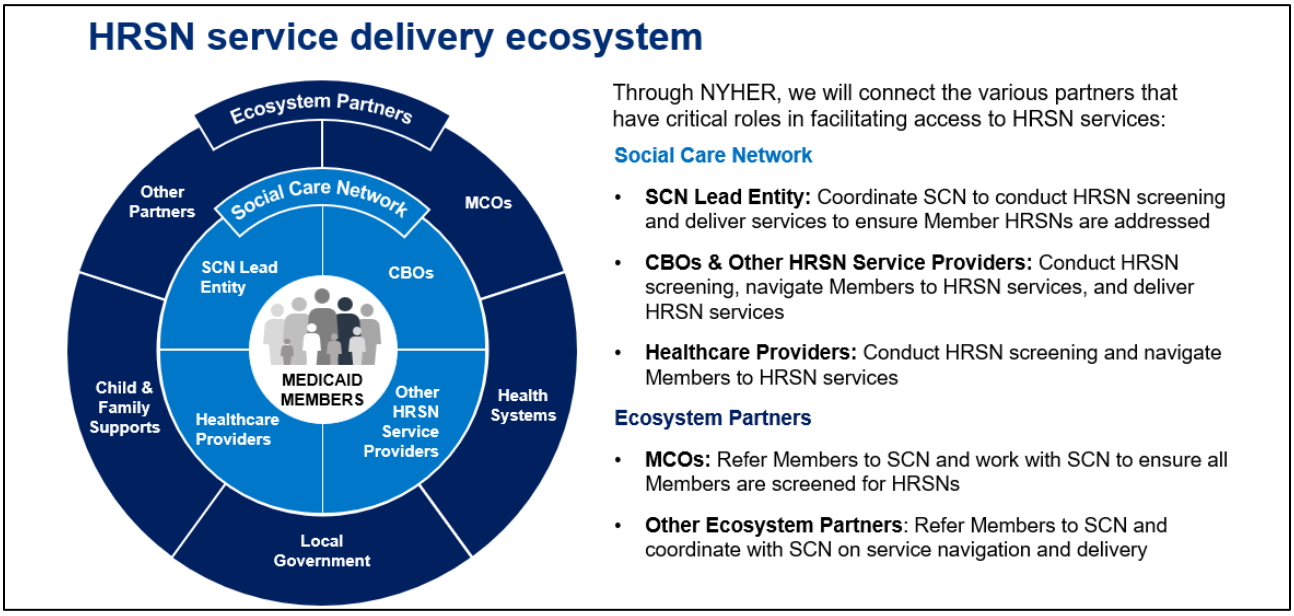
- Build and maintain a comprehensive Social Care Network of contracted organizations that collectively screen all Medicaid members in their region for HRSNs, navigate Members with HRSNs to appropriate services, provide high-quality HRSN services, and provide data and reporting on these activities
- Enroll 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. (*Additional guidance on this process and associated responsibilities is outlined in this Operations Manual*)
- 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 persons, criminal justice-involved populations with chronic or mental health conditions, youth in foster care, high risk children and children with chronic health conditions, and people living with intellectual or developmental disabilities 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 Social Care Network 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 healthcare 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. Fee schedules for HRSN services

To ensure the financial sustainability of the delivery of these HRSN services, OHIP will approve a regional fee schedule submitted by each SCN Lead Entity, with services approved from the Centers for Medicare & Medicaid Services (CMS), to reimburse HRSN service providers for HRSN services provided to eligible Medicaid Members.

c. OVERVIEW OF SCN REGIONS

OHIP has awarded 9 SCN Lead Entities for a contract term running from 8/1/2024 – 3/31/2027. The following organizations were selected and will be covering nine regions throughout the State.

Table 3-1: SCN Lead Entities by region

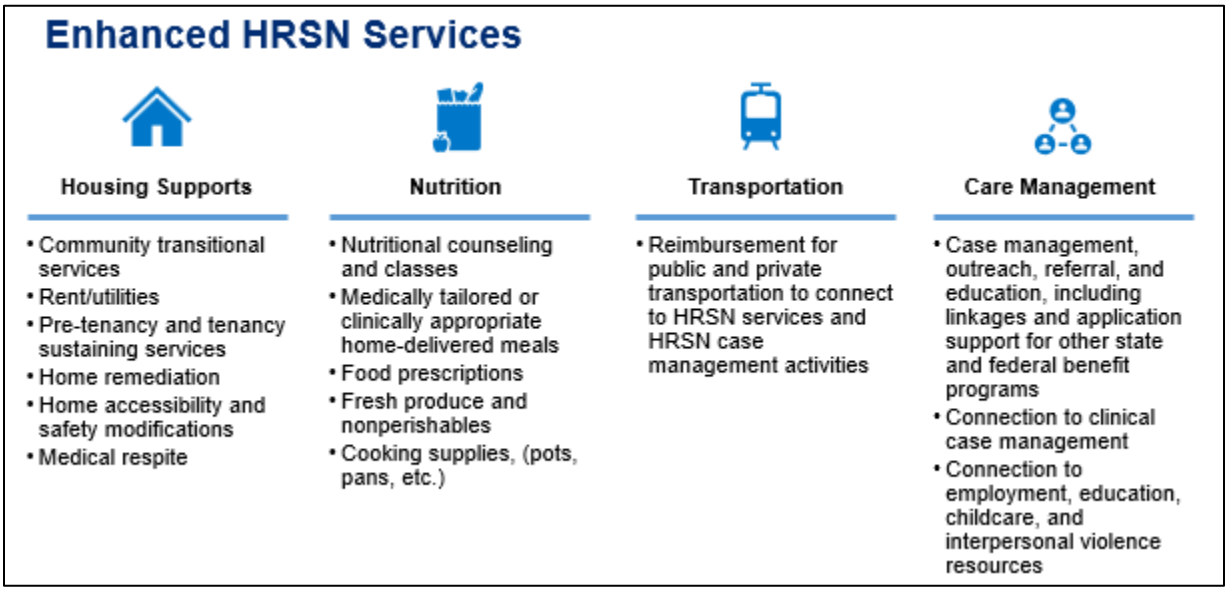
Organization	Region
Care Compass Collaborative	Southern Tier
Finger Lakes IPA Inc.	Finger Lakes
Health and Welfare Council of Long Island	Long Island
Healthy Alliance Foundation Inc.	Capital Region, Central NY, North Country
Hudson Valley Care Coalition, Inc.	Hudson Valley
Public Health Solutions	Manhattan, Queens, Brooklyn
Staten Island Performing Provider System	Staten Island
Somos Healthcare Providers, Inc.	Bronx
Western New York Integrated Care Collaborative Inc.	Western NY
Organization	Region
Care Compass Collaborative	Southern Tier
Finger Lakes IPA Inc.	Finger Lakes
Health and Welfare Council of Long Island	Long Island

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 pre-existing state, federal, and local programs. Services provided by pre-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 Social Care Network and broader ecosystem

- **SCN Lead Entities:** The OHIP-designated Lead Entity will be 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, healthcare 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 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 data flows 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 healthcare 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):** 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 intends for Networks to be comprised of non-profit entities to support the delivery of HRSN services. There may be situations in which SCNs cannot ensure sufficient capacity to deliver HRSN services and meet other SCN responsibilities solely with existing non-profit organizations. SCNs may selectively include for-profit entities where necessary to support access provided that the SCN has fully considered and determined that requirements cannot be fully met by non-profit organizations alone. SCNs are expected to communicate to OHIP via email, or other reasonable communication, 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, at its own discretion, reserves the right to deny inclusion of a for-profit entity from the SCN (s*ee 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

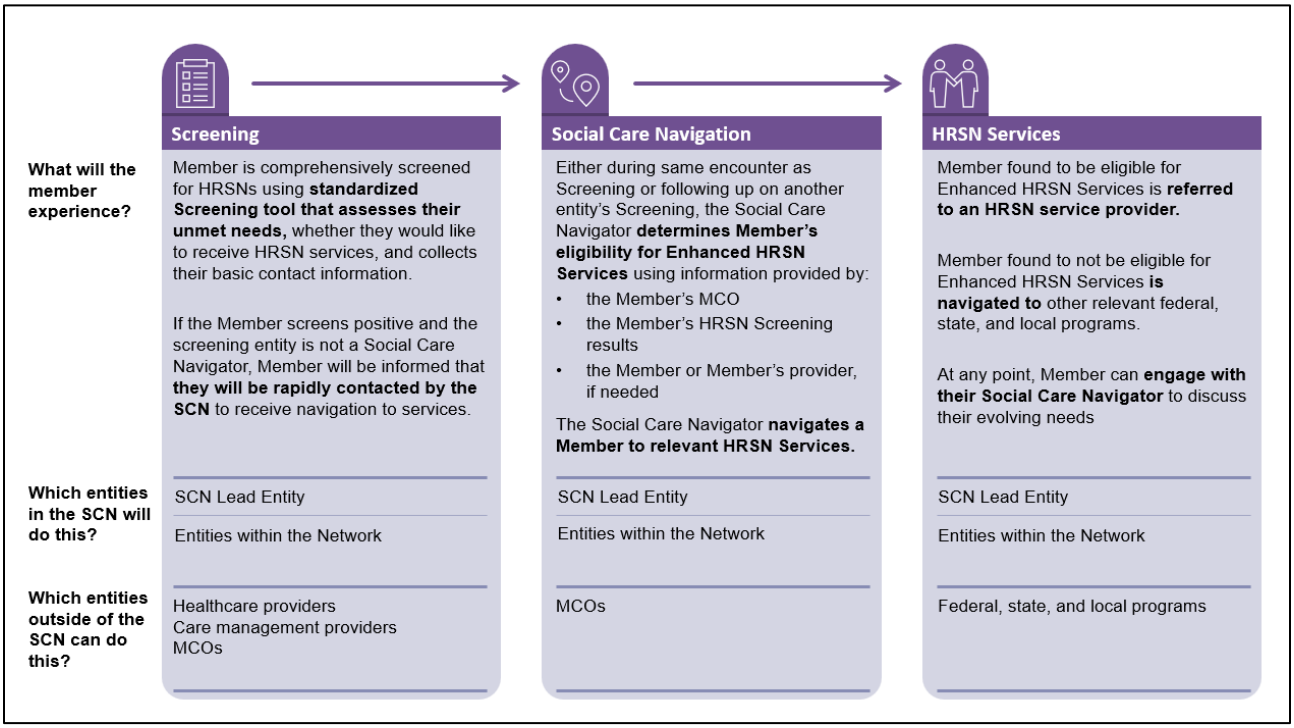
  MCOs with access to the SCN Lead Entity's IT Platform may also provide Screening and Navigation, if designated to do so by the SCN Lead Entity. MCOs are responsible for updating their educational materials (e.g., Member Handbook, Member Notice, MCO Presentation) to inform Members about SCN services.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

- **Health Systems and other healthcare providers:** Health system partners and other healthcare providers, inclusive of both physical health and behavioral health providers, will continue to deliver healthcare services to Medicaid Members in their region. Healthcare 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

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 healthcare 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 healthcare 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 will establish 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 will be held to by OHIP. In some cases, these standards will be *requirements* for SCN Lead Entities. In other cases, these standards are *guidance* that is encouraged and will be monitored but will not be required. SCN Lead Entities will be 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 healthcare 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 will provide 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		
Screening capacity	*See requirement*	○ **75%** of Medicaid population screened in between service start and 3/31/2026 ○ **100%** of Medicaid population screened in between 4/1/2026 – 3/31/2027 *SCNs should aim to meet the initial 75% threshold early in the performance period.*
Eligibility and Navigation capacity	*See requirement*	• Required minimum **85%** of Members with a positive HRSN screen[2] are successfully contacted[1] within **5 business days** • Required minimum **85%** of eligible Members with a positive HRSN screen[2] are provided information for Navigation services **within 7 business days** • Required minimum **85%** of eligible Members with a positive HRSN screen[2] are referred to HRSN Enhanced Services **within 7 business days**
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*
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; however, Members can be navigated to the 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 during Year 1 to establish a baseline; 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) Positive screen 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, at its own discretion, reserves the right to deny inclusion of a for-profit entity from the SCN
- *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 6/9/2024, 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, Chinese, Mandarin, 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 HRSN Services

OHIP expects that SCN Lead Entities establish a Network of HRSN service providers that is able to meet the unique needs and constraints 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 / 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 healthcare 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)

- *Healthcare providers:* OHIP expects that SCNs will work with all interested healthcare 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

OHIP expects SCNs to support capacity building for entities within the Network. In the event of consistent underperformance by HRSN service providers, healthcare providers, or other entities, SCN Lead Entities may disenroll them from the Network.

vii. Expectations for capacity building

SCN Lead Entities will receive infrastructure funding to support capacity building of CBOs in the network. Infrastructure funds cannot be distributed to other HRSN service providers contracted in the SCN. SCN Lead Entities will determine distribution of infrastructure funding across CBOs based on need. SCN Lead Entities should ensure that infrastructure funding is distributed to build CBO capacity across a diverse set of CBOs in the Network. Use of funds for capacity building can include, but is not limited to, direct investments in CBOs to hire staff members to deliver HRSN services and/or perform SCN-related administrative functions, enroll in and successfully use the SCN IT Platform, and provide upfront and ongoing training and technical assistance to CBOs. SCNs are expected to report components of their CBO capacity building in the Infrastructure Cost Report (*see SCN Reporting for details*).

Separate from infrastructure funding, SCN Lead Entities are also responsible for providing onboarding resources to all 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

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 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.

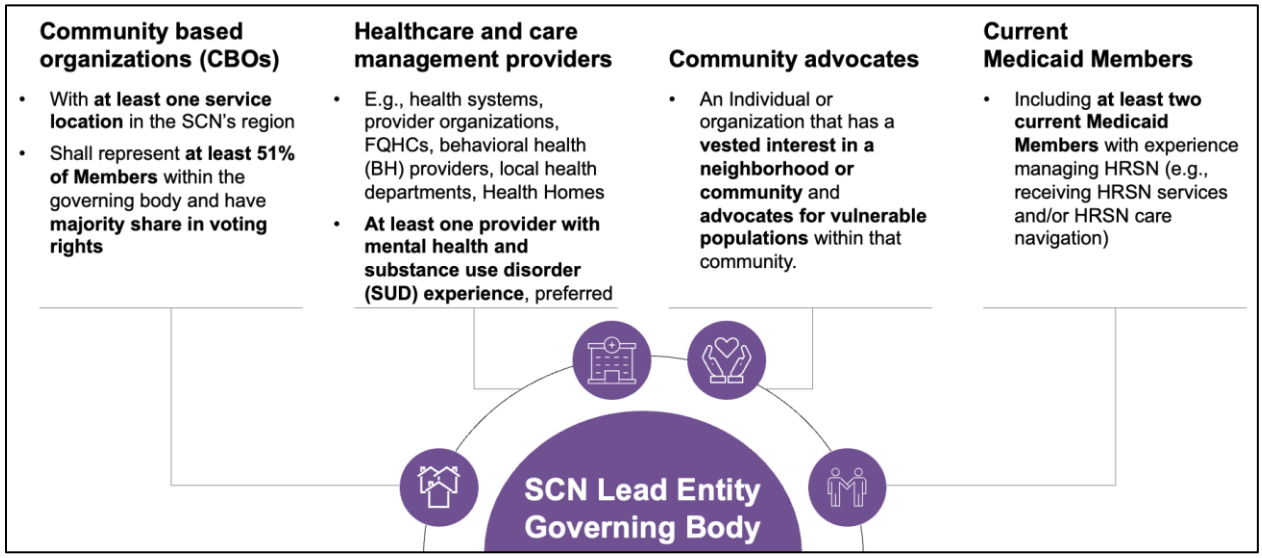
To better understand and address disparities and inequities that can impact Medicaid Members' HRSNs and their ability to access HRSN services, OHIP expects SCN Lead Entities to ensure their governing bodies include a broad and regionally representative group of individuals with diverse backgrounds and 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.
- *Healthcare and care management providers* (e.g., health systems, providers, FQHCs, behavioral health (BH) providers, local health departments, Health Homes) in the SCN region. 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

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. She screens the Member for HRSNs and learns 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 Navigator 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:

- **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. (*For additional details, see User roles, access, and compliance below*)

- **User roles, access, and compliance:**
    - Different organizations in the SCN require unique user roles based on their responsibilities. 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. For example, a 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. The HRSN service provider also does not need access to information about Medicaid Members for whom it does not provide 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 and assess Members using a standardized embedded screening tool (i.e., Accountable Health Communities (AHC) 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 fast healthcare interoperability resources (FHIR) competency

- **Eligibility Assessment:**
    - Enable a user to determine Member eligibility for receiving Enhanced HRSN Services. Enhanced HRSN Services are for Medicaid Managed Care Members in the Enhanced HRSN populations, that screen positive for an unmet HRSN, and wish to receive services
    - Members that are not eligible for Enhanced HRSN Services may be instead 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 do not wish to receive Enhanced HRSN Services will 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. OHIP will provide additional guidance in coming months ahead of the start of service delivery on process / data capture needs for Member attestation

- **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
    - Whether the Referral is open or 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 fee schedule for services delivered, enable HRSN service providers to generate 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.

Table 4-2: 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 • 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 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).
Eligibility Assessment	• The user will be asked to answer a standard list of questions to confirm identity, enrollment, HRSNs, and positive screening conditions • Answers will result in appropriate ICD-10 z-codes and SNOMED-CT codes for unmet HRSNs • OHIP will provide additional guidance in coming months ahead of the start of service delivery on process / data capture needs for Member attestation • The user will confirm Member's desire for services and check the Enhanced Services Member File, and evaluate for 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 provider directory (e.g., name, location, EIN, services provided, contact information) and submit to OHIP annually.

Category	Minimum features / functionalities
	• 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 • 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 (template to be provided by OHIP) including service detail • Track status of claims submission and process electronic data interchange transactions • Track fee schedule-based reimbursement from SCN Lead Entities to entities within the Network • Maintain up-to-date 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/ for 1115 SHIN-NY Interoperability Guidance • Incorporate eligibility files from MCOs 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. OHIP aspires for SCNs to become Health Information Trust Alliance (HITRUST) certified • 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. 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
- Adopt 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

v. 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 Navigation) are appropriately trained to serve Medicaid Members. 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.

SCN Lead Entities should ensure entities in their Network receive training across the following topics as relevant for each stakeholder:

- **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 of this Operations Manual
- **Cultural and linguistic training:** Instruction on being responsive to Members' diverse beliefs, practices, 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
- **Population-specific training:** Instruction on engaging with specific subpopulations including but not limited to:
    - Children and families, including those involved with foster care system
    - Members with intellectual and developmental disabilities
    - Members with Behavioral Health conditions, including Serious Mental Illness (SMI) and Substance Use Disorders (SUD)
    - Criminal justice-involved individuals and juvenile justice-involved youth
- **Child abuse and neglect**: OHIP expects that SCNs provide guidance to Social Care Navigators working with children and youth in their Network to undertake appropriate training and/or equip Navigators to report child abuse or neglect. 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)

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 information on the Network on or before (1/1/2025) as indicated in 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, Member eligibility and process expectations, and introduction to resources made available on the website
- **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, healthcare providers, MCOs, other entities)
    - **Members seeking to reach the SCN** (e.g., seeking screener information, support with Navigation)
- **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*)
- **HRSN screening locations:** Relevant contact information for each screening location (e.g., address, hours, languages spoken, screening modalities offered, etc.)
- **Self-screening optionality:** HRSN screening tool for Members to conduct a self-screen via the SCN website
- **Language translation:** Website offers a language translation option; SCNs may have individuals on staff with necessary linguistic competencies and / or may contract with interpreter services as needed (*see HRSN Network Capacity and Access*)
- **Governing body report:** The SCN Lead Entity shall post its initial governing body convenings to the SCN website, as well as any relevant updates (*see Governance Requirements*)
- **Organization dispute form**: OHIP will establish a dispute process for any organization that is an HRSN service provider or healthcare service provider, through which these organizations can report their exclusion from the SCN. Guidance on specific processes for dispute will be defined in coming months

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.).

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. Screening in the SCN IT Platform
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. Considerations for children, youth, and households
    iv. Situations in which a Member does not respond to outreach for Eligibility Assessment
e) Enhanced Services Member File
    i. Enhanced Services Member File Overview
    ii. Process for creating, sharing, and auditing Enhanced Services Member File
    iii. Information included in Enhanced Services Member File
f) Changes in Member Eligibility
    i. Member disenrollment from Medicaid
    ii. Member movement across SCN regions
g) SCN Referrals
    i. Referrals overview
    ii. SCN Referral process
    iii. SCN Referral tracking
    iv. Distribution of Referrals across Network
h) Social Care Plans
    i. Social Care Plan overview
    ii. Components of Social Care Plans
    iii. Considerations for children and youth
i) HRSN Services

i. Introduction to Member eligibility and medical appropriateness
ii. Covered Populations
iii. Social Risk Factors
iv. Clinical Criteria
v. Covered HRSN Services
vi. Geographic location of service delivery

j) Partnerships
i. State and local partnerships
ii. Statewide Health Equity Regional Organizations (SHERO)
iii. Proactive Member Screening outreach strategies

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

l) 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.

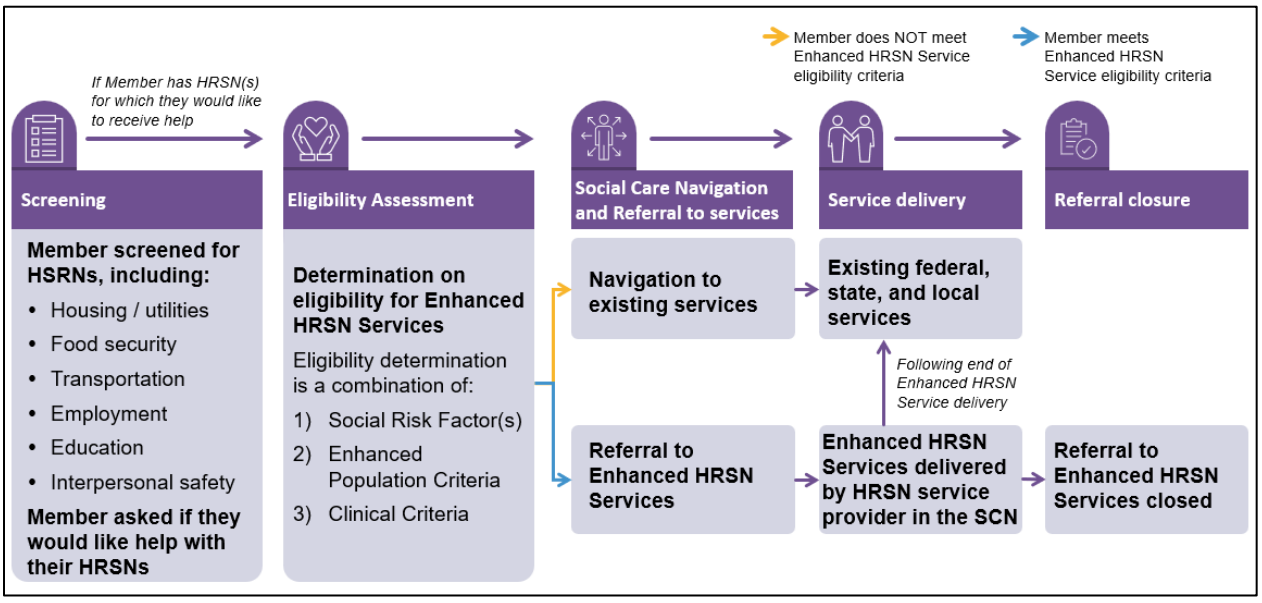
Towards that vision, SCNs will be responsible for administering a core set of responsibilities using standardized processes, tools, and partnerships to ensure consistency and equity in how HRSNs are identified and addressed at scale across regions and across many different HRSN service providers.

The core responsibilities of SCNs are:

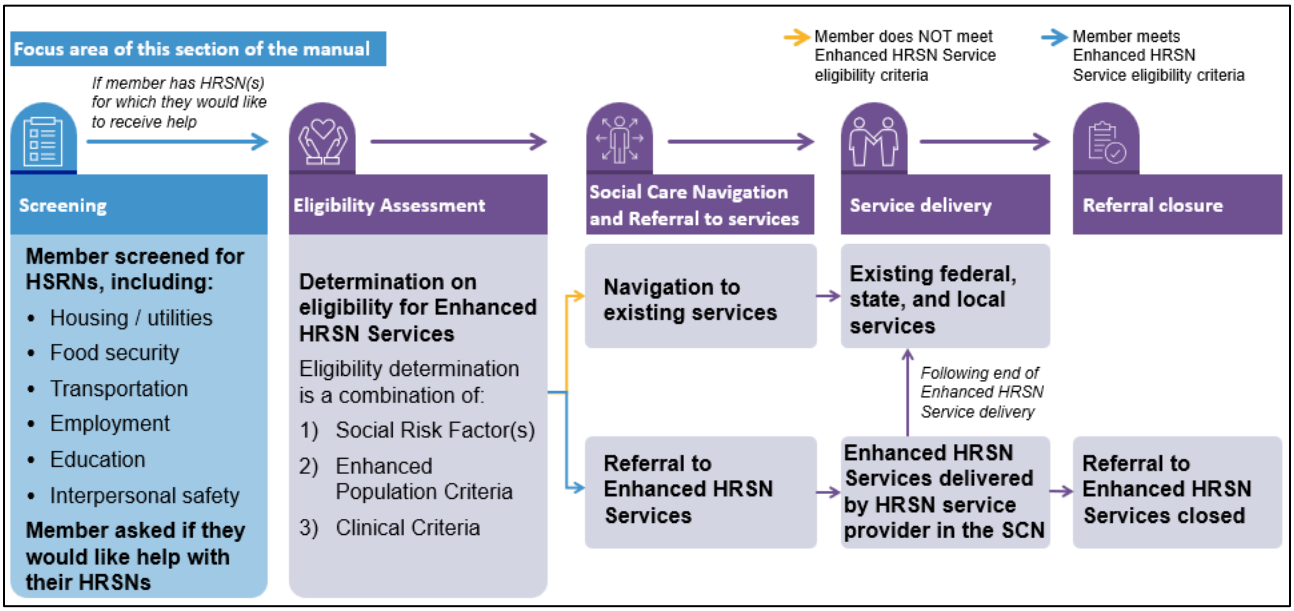
a) **Screen Medicaid Members for HRSNs** in a standardized and person-centered way using the OHIP-standardized version of the Accountable Health Communities (AHC) HRSN screening tool
b) **Conduct Eligibility Assessments** for Members whose screening identifies unmet HRSNs and who request support. Eligibility 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 Enhances HRSN Services** to eligible Managed Medicaid Members
e) **Develop Social Care Plans** that detail Member HRSNs for eligible Medicaid Managed Care Members
f) **Monitor to ensure delivery of Enhanced HRSN Services** and subsequent Referral closure

More detail on each 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 a HRSN screening annually and on an as-needed basis. Members will be screened using a standardized OHIP version of the Accountable Health Communities (AHC) Screening Tool to assess Member HRSNs related to housing and utilities, food security, 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 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, healthcare providers, 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.

Screenings conducted within the SCN:

Screening can be conducted by employees of the SCN Lead Entity or by organizations in the Network. Screening conducted within the Network will receive reimbursement (assuming criteria outlined in Reimbursement for Screening Section below are met). OHIP encourages organizations conducting Screening to join the Network in order to receive reimbursement.

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:

Organizations that are not contracted with the SCN Lead Entity are encouraged to conduct Screenings and upload the results to SHIN-NY. These Screens can then be shared with and acted on by the SCNs via the QE. Screenings conducted by organizations that are not contracted with the SCN Lead Entity will not be reimbursed.

SCN Social Care Navigators are expected to conduct Social Care Navigation for Members who screen positive in a timely manner *(see HRSN Network Capacity and Access)*.

MCOs are encouraged to conduct Screening but will not be reimbursed.

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. 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

a) 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 positive screens 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*)

b) 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 Consent*).

If a Member declines to provide consent, the Screening will not proceed.

c) 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. A major life events 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) *(see Table 5-1)*.

SCNs conducting Screening will receive reimbursement for a Member's first annual screening or upon a major life event requiring a re-screening. Additional screens conducted within a year (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 HRSN Screening annually.
Major life event	Members will also be eligible for reimbursed HRSN Screening if a major life event occurs. 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). 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

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

- *Be conducted on behalf of a Medicaid Member:* While screens of individuals beyond Medicaid Members may be uploaded to SHIN-NY, only screens 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 assessment instrument with identical LOINC coding as the AHC Tool for question-and-answer pairs. Questions cannot be adjusted or changed.

- *Be complete:* All questions in the screening tool – with the exception of interpersonal safety – must have a recorded answer in order to receive payment. Given the sensitive nature of interpersonal safety questions, OHIP recognizes that Members may decline to answer these questions. If one interpersonal safety question is answered, all interpersonal safety questions must then be answered in order to produce a safety score.

  In some cases, a Member may decline to answer select questions in the Screening (e.g., due to discomfort, privacy concerns, etc.). In this event, a Screener can indicate that a Member declined to answer the Screening question. These questions must be logged as a DataAbsentReason. (For further guidance on using DataAbsentReason*, see Screening for Social Risks: LOINC Codes)*

- *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 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 a platform capable of sharing data with the SCN IT platform.

- *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, 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 Members' Social Care Plan (*see Table 5-11 for list of major life events*).

- *Involve 1:1 Member interaction:* Screening must include a 1:1 interaction between the Screener and Member for SCN to be eligible to receive payment. Entities will not receive payment if a Member self-screens without a subsequent 1:1 interaction with a Screener or Navigator.

e) Geographic location of screening: Members can be screened anywhere in the state, regardless of their assigned SCN region. If the Member is screened outside of the assigned SCN region, the screening will be a part of the weekly extract that goes to the assigned SCN, not to the SCN who conducted the screening.

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

SCNs will incorporate a weekly extract 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. If the SCN IT Platform does not have a "last screened" date populated for a specific Member, the Social Care Navigator should also access the designated QE's clinical portal to query any screenings that were conducted that were not part of the pushed screening extract, perhaps due to a prior screening in another SCN region.

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.

g) Screening of children and youth: Our 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 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 healthcare services). The child can consent to sharing Screening information.

- *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 foster parent complete the screening on the minor's behalf.

- *Training requirements to screen children and youth:* The state 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 case notes.

- *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 a New York State-standardized version of the 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, food security, 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.

Alternative screening instruments can be utilized if identical question and answer pairs with corresponding approved LOINC coding are utilized and the language of the questions are not altered. Since the NYHER program requires the use of coding and exchange data standards, it remains agnostic to specific assessment instruments and IT platforms, as long as the required data standards are implemented. This ensures the data utilized in the program is open source and accounts for the infrastructure that ecosystem partners already have in place.

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).*

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)*
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)*
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)*

vi. Screening in the SCN IT Platform

The SCN IT Platform will house HRSN screening data for Members who are screened by the SCN, including:

- *Member contact information,* including name, address, phone number, and email (if available)
- *Basic data about Member identity, i*ncluding but not limited to location, race, ethnicity, age, physical disabilities and sexual orientation and gender identity (SOGI)
- *Member's HRSNs across the six domains covered by the Screening Tool*. ACH 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
- *Whether the Member is interested in receiving support for unmet HRSNs*
- *Member consent for data sharing:* If a Member declines to give consent for data-sharing:
    - The Screening will end
    - The Screening will not be paid for by the SCN
- *Individual who responded to screening* (e.g., the Member or a parent or guardian) 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
- *Language in which screening was conducted* and whether an interpreter was used

Providers that do NOT use the SCN IT platform

Contracted Screening entities can use unique screening IT platforms independent from the SCN IT Platform if the system in which the screening is conducted is interoperable with the SCN IT Platform and screening question and answer pairs utilized have the same LOINC coding as those utilized in the AHC HRSN Screening Tool. This allows data to be seamlessly integrated into the SCN IT Platform and ingested by the SHIN-NY.

Social Care Providers using platforms other than the SCN IT Platform may receive payment for Screening as long as the screening entity is contracted with the SCN Lead Entity and the screening data applies the use of the data standards explained above.

Since the NYHER program requires the use of coding and exchange data standards, it remains agnostic to specific assessment instruments and IT platforms, as long as the required data standards are implemented. This ensures the data utilized in the program is open source and accounts for the infrastructure that ecosystem partners already have in place.

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 healthcare providers) or MCOs. For example, care managers or resource coordinators employed by MCOs, healthcare providers, or care management providers may play 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 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 Navigators will be Community Health Workers. 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 a fee schedule for care management (for 30-minute increments). Attempts by a Navigator to contact a Member (e.g., if a Member cannot be reached after a positive screen) will not be reimbursed.

iii. Navigation Process

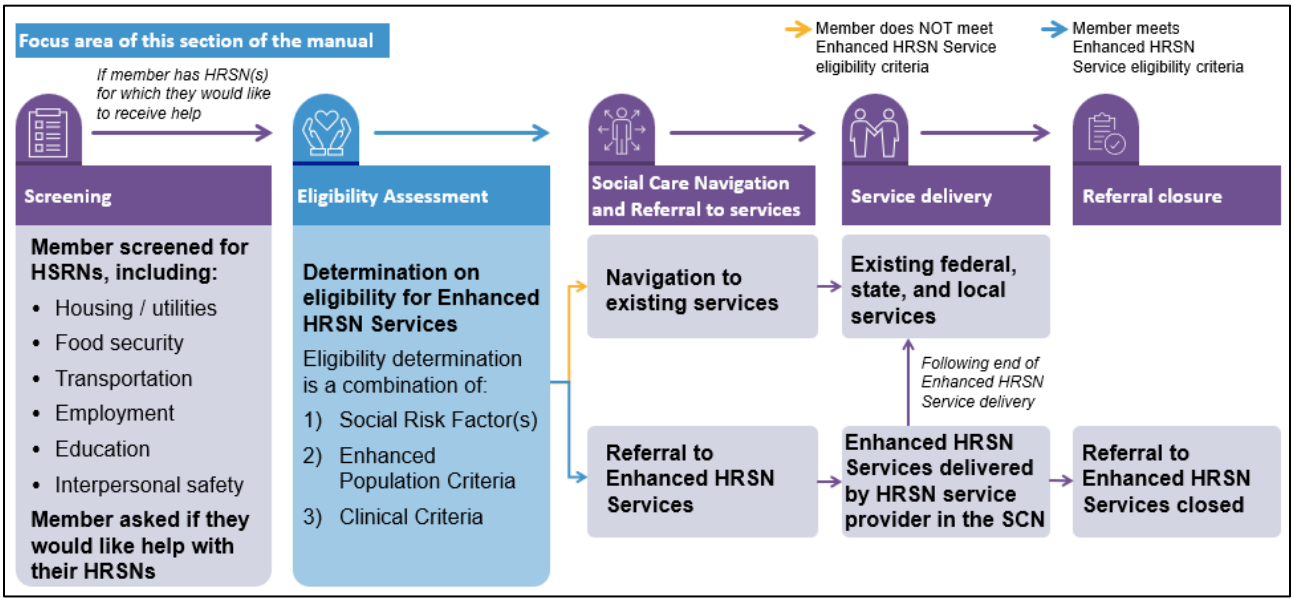
The Navigation process includes validating Member eligibility for Enhanced HRSN Services, managing Closed Loop Referrals for HRSN Services, and developing Social Care Plans for eligible Medicaid Managed Care Members.

Eligibility Assessment. This includes working with the Member to confirm their HRSNs; 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 healthcare 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.

Social Care Plans. 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 what HRSN services can be appropriately reimbursed using Medicaid dollars. All Medicaid Members, both FFS and Medicaid Managed Care, whose HRSN screens demonstrate unmet HRSNs and who are interested in receiving support for those needs should receive an HRSN Eligibility Assessment.

Enhanced HRSN Services will be provided to Medicaid Managed Care Members who meet certain criteria for which there is evidence that a specific HRSN service can improve their health (*see Table 5-3*). 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.

Eligible populations:

Eligibility criteria are subject to change. For latest eligibility criteria, refer to: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm

- **Medicaid fee-for-service (FFS):** The Medicaid FFS population will only be eligible for Navigation to existing federal, state, and local services.
    - *Some FFS populations are not eligible for NYHER Screening and Navigation. A preliminary list of these populations includes:*
        - Members with provisional eligibility for Medicaid benefits
        - Members participating in the Medicare Savings Program
        - Members exclusively in the Family Planning Benefit Programs
        - Members residing in a state psychiatric facility
        - Members who are currently incarcerated

- Members who are eligible for emergency services only

- **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 5-3 below as determined during an Eligibility Assessment and screens positive on the AHC HRSN Screening Tool for an HRSN, they will be 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 MMC
    - HIV Special Needs Plans (HIV-SNPS)
    - Health and Recovery Plans (HARP

  - *Some Medicaid Managed Care lines of business are NOT eligible for some Enhanced HRSN Services:*
    - **MLTCP and MAP:** MLTCP and MAP Members are NOT eligible for Nutrition services. They may be eligible to receive other Enhanced HRSN Services. The SCN Lead Entity should coordinate with plans prior to providing Enhanced HRSN Services.

  - *Some Medicaid Managed Care Members are eligible for Navigation only:* Medicaid Managed Care Members who do not meet population criteria in Table 5-3 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 opt to be navigated to existing federal, state, and local services instead of Enhanced HRSN Services.

Table 5-3: Populations eligible for Navigation and Enhanced HRSN Services

Eligible Populations are subject to change pending CMS approval. For latest eligibility criteria, refer to: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm

Navigation services	**Medicaid FFS Members** and enrolled **Medicaid Managed Care Members** who do not meet Enhanced Population criteria for Enhanced HRSN Services below. Members will receive navigation to existing federal, state, and local services to address HRSNs.
Enhanced HRSN Services	**Enrolled Medicaid Managed Care Members**, who meet one or more of the following criteria, screen positive for an unmet HRSN, and are confirmed during an Eligibility Assessment for having an unmet HRSN.

	Enhanced HRSN Services criteria (additional details follow in HRSN Services Section): i. *Medicaid High Utilizer* (defined by Emergency Department or inpatient utilization, or transitioned from an institutional setting in the past 90 days and has a chronic condition, including a mental health condition or physical disability) ii. *Individuals enrolled in a NYS-designated Health Home*, which currently includes individuals with HIV/AIDs, Serious Mental Illness, Serious Emotional Disturbance, Complex Trauma, 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, sickle cell, or HIV/AIDS) *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. *Juvenile justice involved youth*, *foster care youth*, and those under *kinship care* *ix.* *High-risk children under the age of six* x. *Children under the age of 18 with one or more chronic conditions* including mental health conditions (such as diabetes, CHF, chronic kidney disease, COPD, pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS, depression, anxiety)

Eligibility timeframe: Enhanced HRSN Services will be delivered by SCN for a pre-determined duration period. Most HRSN services will be delivered for up to 6 months and may be used in increments. Some Members may be eligible to receive services for longer periods (e.g., pregnant individuals can receive select Nutrition services for a duration period of 11 months) *(see Covered HRSN Services)*.

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.

SCN assignment: Medicaid Members are assigned to an SCN region based on their latest residential address by county (not zip code). Members must receive services in the SCN to which they are assigned. If a Member moves out of one regional SCN service area and into another, the SCNs will coordinate with the MCOs to update their record and enable hand-off of the Member *(see Member movement across SCN regions)*.

ii. Eligibility Assessment Process

Once a Member is screened and found to have an unmet HRSN, a Social Care Navigator will assess the Member's eligibility to receive Enhanced HRSN Services. *(For a high-level over 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 Navigator can also ask additional questions to better understand the Member's needs.

Members will be expected to attest to the accuracy of information provided through the Eligibility Assessment. Additional details on how this attestation will be collected by Social Care Navigators is forthcoming.

Figure 5-2: Eligibility Assessment activities

Eligibility Assessment *(All Medicaid populations)*				
Step		**Activity***	**Details**	**Data reference**
1		**Confirm Member identity and Medicaid enrollment**	Check Member Medicaid enrollment in ePACES	• ePACES
2		**Confirm HRSN**	Check the SCN IT Platform for HRSN Screening results and confirm with Member	• AHC HRSN Screening results
3		**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
4		**Check Enhanced Population**	Check if Member is part of an Enhanced Population in the Enhanced Services Member File	• Enhanced Services Member File • Member input
5		**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 6-8.	6	**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	• Enhanced Services Member File • Member input
	7	**Confirm desire for services**	Inquire if Member would like to receive Enhanced HRSN Services for which they are eligible	• Member input
	8	**Create care plan**	Develop Social Care Plan for Member on the SCN IT Platform based on unmet HRSNs and eligibility criteria gathered	• Questions built into SCN IT Platform

*These activities can only be done by Social Care Navigators on the SCN IT Platform

Overview of each Eligibility Assessment step

1. *Confirm the Member's identity and their Medicaid enrollment*: Check ePACES to confirm Medicaid enrollment status for both Fee-For-Service and Managed Care Members.

2. *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. Unmet HRSNs (positive screening responses) will be mapped to ICD 10 Z codes and SNOMED-CT codes by the SCN IT Platform (*see Eligibility Assessment Coding)*

3. *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.

4. *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 Navigator should ensure that the Member they are assessing matches the Member listed in the Enhanced Service Member File using the "Member Identifier" fields. The 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 two instances in which the information from the interaction between the Navigator and the Member *supersedes* information found in the Enhanced Services Member File. Additional details about both these instances are forthcoming.

   1: Information involving Enhanced Population criteria and clinical criteria that are eligible for Member attestation with documentation

   2: Information involving Enhanced Population criteria and clinical criteria that are eligible for the Member's Provider to submit supporting documentation

   In the event the Social Care Navigator learns of information not included in the Enhanced Services Member File, the Social Care Navigator will inform the MCO. Additional details about this process are forthcoming.

   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 Navigator should not request that the MCO remove information from the Member File. Members always have the option to decline services.

5. *Ask Member follow-up questions to better understand their unmet HRSNs:* Follow-up questions built into SCN IT Platform allow the Navigator to better understand the nature of the Member's HRSNs and what services are most appropriate.

   Through these questions, the Navigator will Identify if there is an opportunity to enroll the Member in federal benefits for relevant services such as SNAP, WIC, or TANF. If the Member is currently receiving federal benefits, the Navigator should identify what additional services are being provided to the Member to avoid any potential duplication of services.

   The following questions are examples of yes / no follow-up questions that may be asked of Members based on HRSN needs:

   General
   - Is the Member enrolled in TANF (OTDA)? *If the Member is enrolled in Managed Care and eligible for TANF, the Navigator can assist with a TANF application.*
   - What is the Member's current employment status?
   - Does the Member have income from any source?
   - How many people are in the Member's household?

   Housing
   - What type of housing assistance does the Member need?
   - Is their household currently working with a housing provider?

- Is the Member on any housing waitlists (i.e., HUD. Section 8, local housing authority, or other voucher programs)?
- How many people are in the Member's household?

Food

- What type of food assistance does the Member need?
- Is the member enrolled in SNAP (OTDA) and WIC? If the Member is enrolled in Managed Care and eligible for SNAP or WIC, the Navigator can assist with an application.
- Is the Member receiving any home-delivered meals or food services?
- Is the Member currently receiving nutritional counseling or education?
- Is the Member receiving any other nutrition services?
- How many people in the Member's household need food assistance?
- Does the Member have a valid state-issued ID?
- On which days would the Member like to have meals delivered? (M-S)
- Does the Member have the ability to store food, such as a refrigerator?
- Does the Member have any dietary restrictions or food allergies?

Transportation

- 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?

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 Navigator can opt to receive the care manager's contact information from the Member and coordinate HRSN service delivery with an existing care manager.

6. *Confirm the Member's eligibility for HRSN Services, including 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 Navigator needs to confirm that the member is eligible for one or more Enhanced HRSN Services and is not already receiving duplicative services.

   First, the Navigator should check that the Member meets Social Risk Factor Descriptions and clinical criteria identified during the Eligibility Assessment and confirm that the Member meets the criteria for a given Enhanced HRSN Service *(for additional details, see HRSN Services)*. Only criteria pertaining to relevant Enhanced HRSN Services should be checked.

   Then, the 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 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 necessarily duplicative of receiving a home-delivered meal, even though both involve food.

7. *Confirm that the Medicaid Managed Care Member wants to receive Enhanced HRSN Services for which they are eligible:* The 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.

8. *Create a Social Care Plan that is tailored to the Medicaid Managed Care Member's specific needs:* Finally, Navigators should develop a Social Care Plan for Medicaid screening members (*see Social Care Plans.*). Member goals identified in Social Care Plans will be mapped to SNOMED Goal Codes by the SCN IT Platform (*see Eligibility Assessment Coding).*

iii. Considerations for children, youth, and households

OHIP expects that SCNs address the needs not just of individuals, but of everyone else in their families and households, including children. As with screening, SCN organizations working with children and youth are expected to understand their legal obligations to establishing eligibility requirements for children and youth specifically.

Eligibility for Enhanced HRSN Services will be assessed individually for each Member. Their eligibility is not impacted by whether other family / household members are eligible or receiving HRSN services, or by whether other family / household members are eligible for Medicaid.

SCNs are encouraged to identify all household members eligible for services and should factor in other household Members in the development of an individual's Social Care Plan. For example, a child's Social Care Plan could include actions to meet her mother's unmet social needs, even if her mother is not eligible for HRSN services within the SCN program.

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

If the Member does not respond to outreach from a Navigator to conduct an Eligibility Assessment after screening positive for unmet HRSNs, the Navigator is required to:

- Make at least three (3) outreach attempts within five (5) business days
- Conduct outreach activities across multiple modalities (e.g., phone call, text, e-mail)
- Document each attempted outreach in the SCN IT Platform

Outreach to the Member will not be reimbursed.

e. ENHANCED SERVICES MEMBER FILE

i. Enhanced Services Member File Overview

The Enhanced Services Member File 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 Enhanced Services Member File will:

- Include all Medicaid Managed Care plan 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, juvenile justice-involved, foster care youth)
- *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 Enhanced Services Member File

Process by which the Enhanced Services Member File will be created:

OHIP will provide a state-prescribed Enhanced Services Member File Template to the MCOs. MCOs will then use the Enhanced Services Member File Template to:

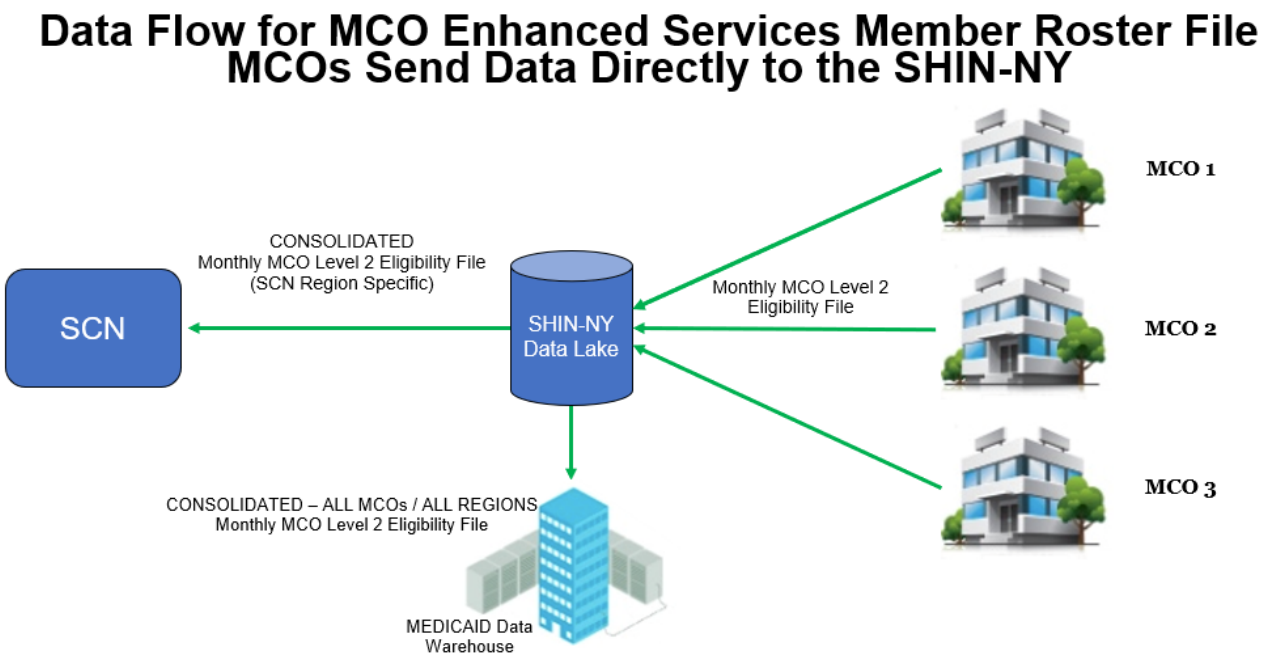
- Create their own algorithm to query all plan Members and associated HRSN eligibility criteria
- Populate template with all plan Members and their HRSN eligibility information
- MCOs will be responsible for cumulatively reporting all plan Members, including Members with voluntary or involuntary disenrollment
- Send the Enhanced Services Member File to the NYeC/SHIN-NY data lake by the 1st of every month

Process by which the Enhanced Services Member File will be shared:

Once NYeC/SHIN-NY receives the Enhanced Services Member File:

- SHIN-NY will send a monthly Enhanced Services Member File to New York State's Medicaid Data Warehouse (MDW)
- The QE partner will obtain the Enhanced Services Member File 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 5-3: Process for sharing of Enhanced Services Member File



Process by which the Enhanced Services Member File will be audited and updated:

- The entirety of the Enhanced Services Member File must be audited each month by the MCO to ensure a Member's eligibility for Enhanced HRSN Services is up-to-date and accurate
- There are instances in which the SCN can submit updated information to the MCO to be updated in the next month's Enhanced Services Member File
    - **A Member has a change in Enhanced Population eligibility:** The Navigator determines during an Eligibility Assessment that a Member meets an Enhanced Population's criteria, but the Member was not indicated as eligible on the current Enhanced Services Member File
    - **A Member has a change in eligibility for a specific HRSN service:** The Navigator determines during an Eligibility Assessment that the Member meets the clinical criteria required for a specific Enhanced HRSN Service, but it is not indicated on the current Enhanced Services Member File (i.e., pregnancy)
    - **Risk criteria has previously not been reported to the MCO:** In some cases, a Member may meet eligibility criteria that has not been reported by their current MCO (e.g., due to recent enrollment, change in MCO)
    - In instances in which there is inconsistency between SCN Eligibility Assessment and the Enhanced Services Member File, the SCN Social Care Navigator will make the ultimate determination of Member eligibility and may proceed with Referral to Enhanced HRSN Services (the Navigator does NOT need to wait until the Enhanced Member Services File is updated)

- Across these instances, the SCN Lead Entities and MCO will follow the following procedure to ensure the Enhanced Services Member File is updated in a timely manner:
    - The SCN Lead Entity must document new information and send a service request to the MCO within five (5) days of Eligibility Assessment for the MCO to update their Enhanced Services Member File
    - MCOs will create an appropriate workflow and will have a designated point person to:
        - Receive new eligibility criteria to add to the File as relevant
        - Update Care Management records if needed
    - MCOs can provide response via email or other written form to the SCN Lead Entity once new criteria have been added

iii. Information included in Enhanced Services Member File

The Enhanced Services Member File must include all Members enrolled in a MCO regardless of Enhanced Population status and be cumulative (continuous reporting regardless of inactive status) to include all retroactive voluntary or involuntary disenrollment (e.g., due to Member's death, MCO plan change, or any other disenrollment reason whether voluntary or involuntary).

Data elements of the Enhanced Services Member File include:

- Plan ID
    - The identification number of the Managed Care Organization that the Member is enrolled
- Line of Business
    - A complete list of Lines of Business can be found in SCN Contracting section
- Member Identifiers
  Social Care Navigator will use the following data elements to verify that the Member presenting is the same Member in the IT Platform and the Enhanced Services Member File
    - Member's Medicaid number / CIN
    - Member's last name
    - Member's first name
    - Member's Social Security number
    - Member's date of birth
    - Member's address
    - Member's county
- Enhanced Populations Flags
    - MCO's determination of eligibility for the Enhanced Populations
- Clinical Criteria Flags
    - MCOs will flag clinical criteria to assist Navigators with determining eligibility for specific services or Enhanced Populations
- Service Duplication Flags

    - MCOs will flag indicators of potential service duplication with existing Medicaid-funded services on the Enhanced Services Member File

- MCO Enrollment Date
    - The enrollment date from the Member's most recent continuous enrollment with the MCO
    - The enrollment date can provide a general baseline the Navigator to understand how much historical data the MCO may have on a Member

- MCO Prospective Disenrollment Date
    - If the MCO is aware of a prospective disenrollment date

f. CHANGES IN MEMBER ELIGIBILITY

Over the course of the SCN Program, it is possible that Members experience changes in Medicaid eligibility. OHIP aims to maximize Member access to Enhanced HRSN Services and to ensure that all eligible Members receive Enhanced HRSN Services. The processes below are intended to support continuity of care.

i. Member disenrollment from Medicaid

If a Member becomes disenrolled from Medicaid during the course of Enhanced HRSN Service delivery, OHIP aims to ensure this information is conveyed as soon as possible to all relevant parties such that HRSN service delivery ends a the time of disenrollment.

Process for routine and "other than routine" changes in Medicaid eligibility

1. **Routine changes in Medicaid eligibility ("prospective" advanced notice of disenrollment)**

    - The Member's MCO updates and shares Medicaid enrollment information on the 1st of the month in the Enhanced Services Member File (Medicaid Prospective Disenrollment Dates field)
    - Upon receiving updated disenrollment data within the Enhanced Services Member File, the Member's Social Care Navigator is responsible for:
        - Confirming with the Member their upcoming disenrollment, and assisting the Member with re-enrollment if the Member is eligible and desires to re-enroll
        - Determining if the Member's scheduled Enhanced HRSN Service end date is at or after the Prospective Medicaid Disenrollment Date
    - In instances in which the Member is scheduled to received Enhanced Services beyond the date at which their Medicaid eligibility is scheduled to end, the Navigator is required to inform:
        - The Member of their upcoming disenrollment date and end of Enhanced HRSN Service Delivery, as well as existing state, local, and federal resources available
        - The HRSN service provider of the date at which they need to end service delivery (as this is the last date at which services delivered can be reimbursed)
    - The HRSN service provider is then responsible for adjusting service delivery to match the updated end of service delivery date communicated by the Social Care Navigator

2. **"Other than routine" changes in Medicaid eligibility:**

In the less frequent case in which a Member's Medicaid disenrollment is considered "other than routine" and the Member's enrollment status changes *during the course of a month* (i.e., after the Enhanced Services Member file is shared on the 1st of the month), it will be the responsibility of the MCO to provide updated information on the Member's disenrollment date in a timely manner to the SCN Lead Entity.

The SCN Lead Entity will need to share disenrollment information with the Member's Social Care Navigator and any entities delivering Enhanced HRSN Services to the Member. Services should NOT be delivered after a Member has disenrolled from Medicaid.

OHIP will provide additional details on this process in forthcoming guidance.

Financial implications of Enhances HRSN Services delivered after Member disenrollment from Medicaid
In situations in which a Member receives Enhanced HRSN Services for which they are ineligible, e.g., due to a change in Medicaid enrollment, the financial cost for the cost of that service delivery will be the responsibility of the SCN Lead Entity.

Exceptions to this will occur in the following circumstances:

- If the MCO does not convey new information on Medicaid eligibility changes to the SCN Lead Entity according to the specified timing guidelines, the MCO will be responsible for the cost of service delivery
- If the SCN Lead Entity informs the HRSN service provider of Medicaid eligibility changes but the HRSN service provider does not end service delivery, the HRSN service provider will be responsible for the cost of service delivery

OHIP will provide additional details on this process in forthcoming guidance.

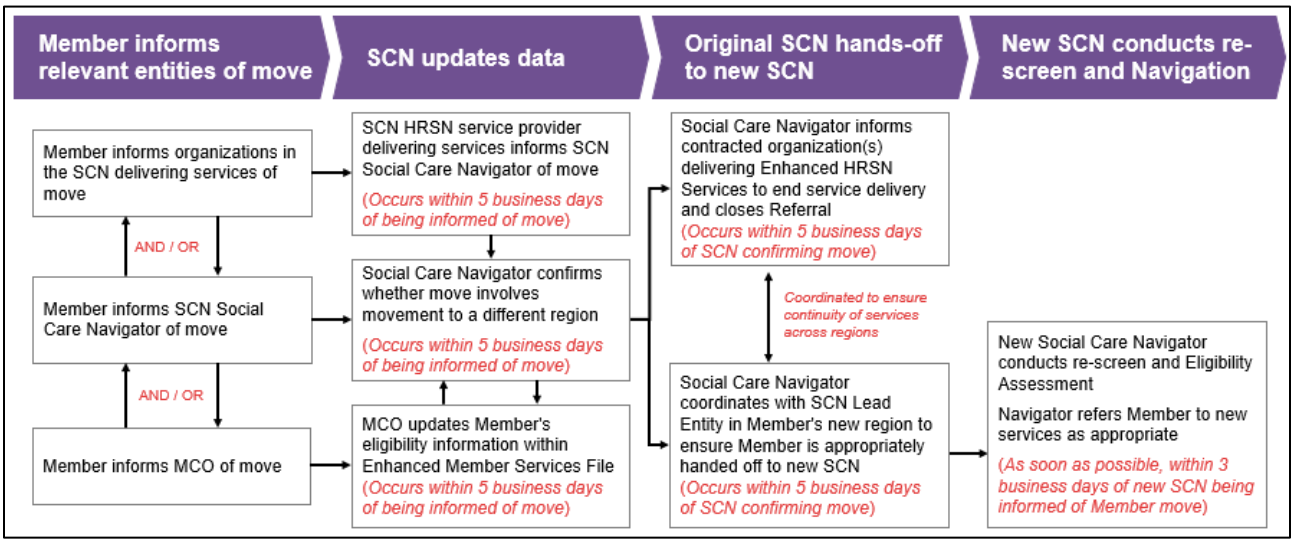
ii. Member movement across SCN regions

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 anew SCN lead Entity.

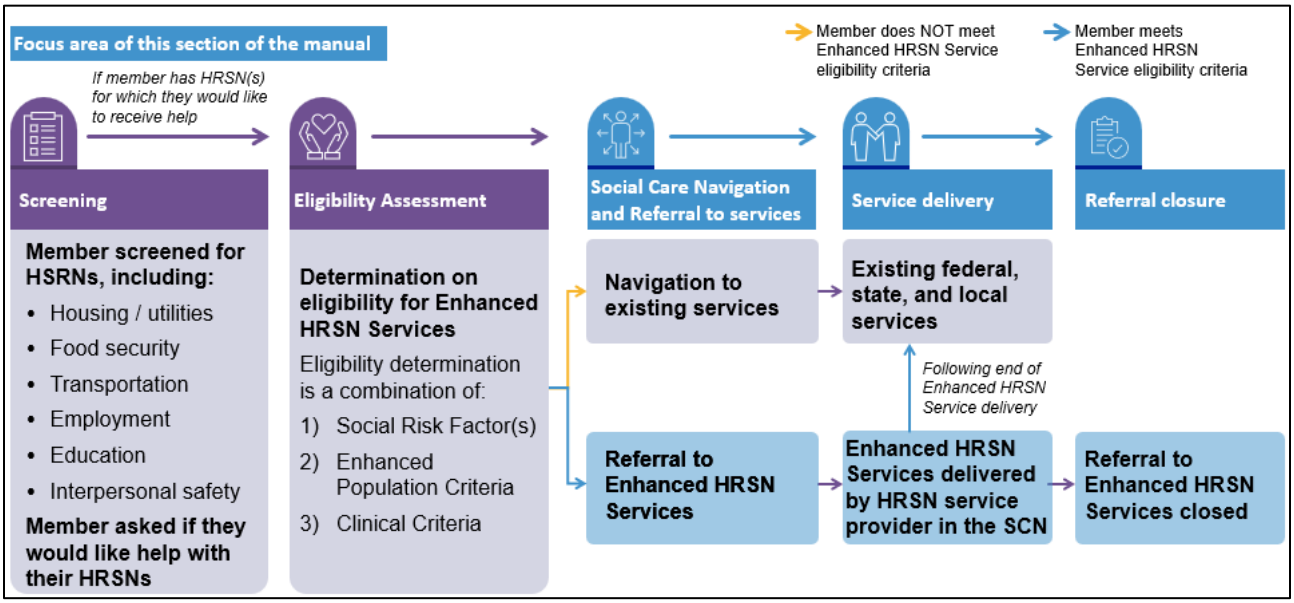
The process for updating the Member's assigned SCN will proceed as follows (*see Figure 5-5*):

- When a Member moves to a new SCN region, they will ideally inform their Navigator, MCO, and HRSN service providers of their move. It is the responsibility of each entity to ensure that the others are informed. For example, if the current Navigator becomes aware of a Member's move to a new region, the Navigator will update any currently engaged HRSN service providers to ensure they stop delivering services and the Member's MCO to ensure the MCO has the most up-to-date address
- If Members do not inform any of the current entities within their region and first seek care at a new SCN, it will be the responsibility of the new SCN Lead Entity to inform the previous SCN Lead Entity of the Member's move
- As part of the transition of care, the Member's Social Care Navigator in the original location 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.

Figure 5-5: Process flow for Members that move between SCN regions


Member informs relevant entities of move
SCN updates data
Original SCN hands-off to new SCN
New SCN conducts re-screen and Navigation
Member informs organizations in the SCN delivering services of move
AND / OR
Member informs SCN Social Care Navigator of move
AND / OR
Member informs MCO of move
SCN HRSN service provider delivering services informs SCN Social Care Navigator of move
(Occurs within 5 business days of being informed of move)
Social Care Navigator confirms whether move involves movement to a different region
(Occurs within 5 business days of being informed of move)
MCO updates Member's eligibility information within Enhanced Member Services File
(Occurs within 5 business days of being informed of move)
Social Care Navigator informs contracted organization(s) delivering Enhanced HRSN Services to end service delivery and closes Referral
(Occurs within 5 business days of SCN confirming move)
Coordinated to ensure continuity of services across regions
Social Care Navigator coordinates with SCN Lead Entity in Member's new region to ensure Member is appropriately handed off to new SCN
(Occurs within 5 business days of SCN confirming move)
New Social Care Navigator conducts re-screen and Eligibility Assessment
Navigator refers Member to new services as appropriate
(As soon as possible, within 3 business days of new SCN being informed of Member move)

g. SCN REFERRALS



i. Referrals Overview

Referrals to Enhanced HRSN Services will be a core element of this program, wherein Social Care Navigators connect eligible Members to services, care providers, and community resources. These will be 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.

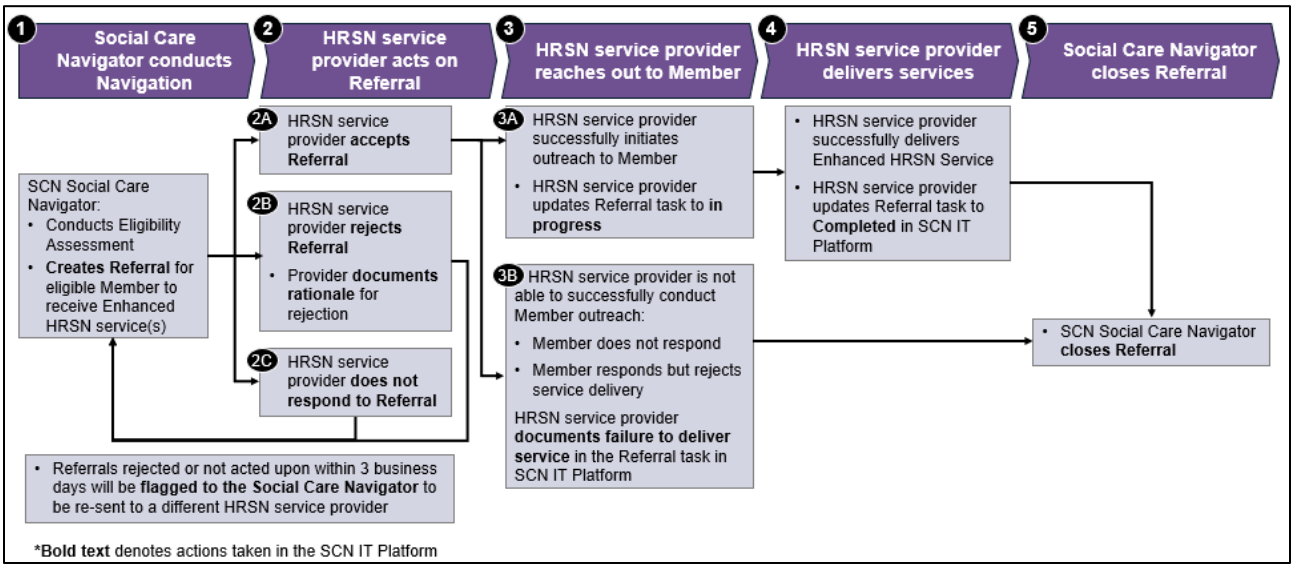
This section outlines:

- **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. SCN Referral process

Social Care Navigators are responsible for initiating Referrals for Enhanced HRSN Services to HRSN service providers, who then contact the Member and initiate service delivery. This Referral process, from initial Referral request through HRSN service delivery and Referral closure is detailed below.

Figure 5-6: Process flow for Referrals for Enhanced HRSN Services, from initial creation through Referral closure



Step 1. Referral to HRSN service provider

The Social Care Navigator creates Referrals to Enhanced HRSN Service(s) for eligible Members, according to the following guidelines:

i. 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)

ii. 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

iii. The **Social Care Navigator will input notes into the Member's Social Care Plan** that will be visible to organizations providing Enhanced HRSN Services to the Member

"Priority" or "Urgent" needs workflows:

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.

Step 2. HRSN service provider acts on Referral

Upon receiving a Referral for an Enhanced HRSN Service, the HRSN service provider can accept, reject, or not respond to the Referral (see Table 5-4).

Table 5-4: Detailed considerations for HRSN service provider acts on Referral

Step	Options for stakeholder actions	Considerations
2A	HRSN service provider accepts Referral	The HRSN service provider can accept the Referral on the SCN IT Platform by updating the Referral status on the SCN IT Platform to "Accepted" (or "On Hold", if there is a waitlist)
2B	HRSN service provider rejects Referral	The HRSN service provider can reject the Referral (e.g., due to lack of capacity). If a Referral is rejected, the HRSN Service provider must include a narrative reasoning for rejection in the Referral Task on the SCN IT Platform The Social Care Navigator who initiated the Referral is notified that the Referral was rejected and is expected to communicate with the Member an update on the Referral status and update the Referral to a different HRSN service provider
2C	HRSN service provider does not respond to Referral	If the HRSN service provider does not respond to the Referral, the Referral stays open The Social Care Navigator who initiated the Referral is expected to communicate with the Member an update on the Referral status and update the Referral with a different HRSN service provider

Technical considerations across HRSN service provider action options:

- 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. It can, however, be transmitted by the QE for SCN analytics

Step 3. HRSN service provider reaches out to 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". 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 Navigator to be re-screened (and Member must be eligible for 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:

i. Make at least 3 outreach attempts within 5 business days (Note: attempting outreach alone is not reimbursable)
ii. Conduct outreach across multiple modalities (e.g., phone call, text, e-mail)
iii. Document each attempted outreach

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. Aa technical consideration to narrative reasoning for not delivering the service provided by the HRSN service provider, the narrative reasoning in the Referral Task does not meet FHIR standards and would not be transmitted to the SHIN-NY Data Lake. It can, however, be transmitted by the QE for SCN analytics

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

Step 4: HRSN service provider delivers services

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 5-6 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 Pantry-Stocking, the Social Care Navigator should consider offering to transition the Member to an existing service such as WIC or SNAP where applicable

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

Step 5. Social Care Navigator closes Referral

Within 5 days after completion of Enhanced HRSN Service, the Member's Social Care Navigator conducts outreach to the Member *(see Table 5-6 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 programs), where relevant and desired

Upon completing delivery of the Enhanced HRSN Service, the HRSN service provider will update the status of the Referral Task in the SCN IT Platform to "Completed".

Table 5-5: 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	
	1.2 Enhanced HRSN Care Management	N/A	Within 5 business days after service completion
Housing	2.1a Medically necessary home modifications	N/A	Within 5 business days after service completion
	2.1b Medically necessary air conditioners, heaters, humidifiers, dehumidifier	N/A	Within 5 business days after service completion
	2.1c Medically necessary refrigeration units needed for medical treatment	N/A	Within 5 business days after service completion
	2.2 Medically necessary remediation services, repairing or improving ventilation systems, and mold / pest remediation	N/A	Within 5 business days after service completion
	2.3 Asthma remediation	HRSN service provider follows up with the member between 30-45 days after Asthma Remediation services have been provided to administer an asthma control screening to evaluate the impact before and after service competed	Within 5 business days after service completion
	2.4 Medical respite (recuperative care) - pre 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 for up to six months	Ongoing throughout service delivery to assist in transition to additional supports	Within 5 business days after service completion

		AND 60 days before service completion	
	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 services	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 Nutritional counselling and education	60 days before service completion **AND** 10 days before service completion	Within 5 business days after service completion
	3.2 Medically tailored or clinically appropriate 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** 10 days before service completion	Within 5 business days after 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

iii. 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 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;
- At the start of service delivery, a small subset of SNOMED-CT Code Descriptions will not yet have published SNOMED-CT Codes assigned to them. For this subset of codes, OHIP requires SCN IT Platforms to create temporary local codes for the associated SNOMED-CT code descriptions outlined by OHIP. When the new, corresponding SNOMED-CT codes are released to the international community, OHIP will require adoption of these national data standards to replace the temporary local codes as quickly as possible. The code descriptions will already be in place and therefore will not need to be updated with the code itself. The goal will be to use the official SNOMED-CT codes for the duration of the 1115 Waiver and beyond to ensure the NYHER program adheres to national data standards while operating in the broader health and social care data ecosystem
- Each Referral is a Service Request 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 (Open, Accepted, or Closed);
- Time to Closed Loop Referral; and
- Details on services delivered (e.g., type of intervention, duration)
- Service Begin Date: The start of HRSN service duration (Referral acceptance will be tracked as the start of service delivery. If the date of start of service provision is different than Referral acceptance date, this will be tracked through social care claims).
- 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

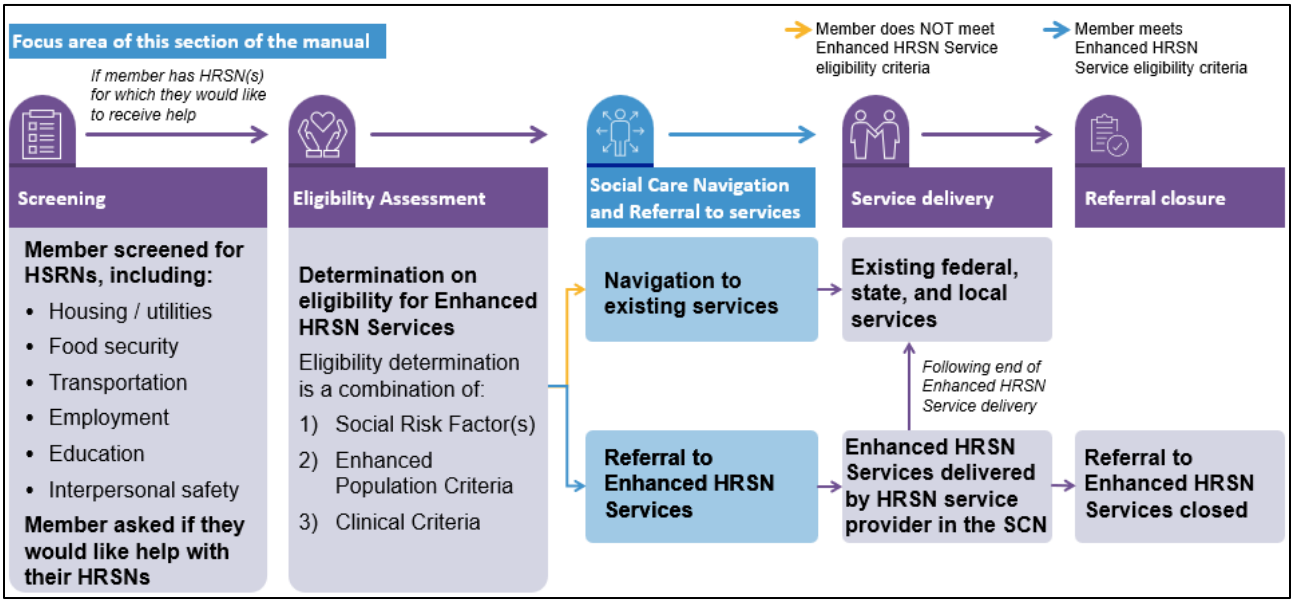
The SCN Lead Entity will be responsible for reporting this information and additional performance detail monthly to OHIP (Discussed further in ***Performance and Payment*** Section).

iv. Distribution of Referrals across Network

SCNs should strive to ensure a balanced distribution of Referrals across organizations in the Network. Organizations conducting Screening and Navigation should consider both external Referrals (Referrals to other organizations in the Network) in addition to accepting the Referral themselves.

OHIP will not set a directive on 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.

h. SOCIAL CARE PLANS



i. Social Care Plan overview

Each Member in an Enhanced Services Population will have a Social Care Plan developed during Navigation. 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 developed 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 housed in the SCN IT Platform.

For Members belonging to Enhanced Services Population(s), the process 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.

The number of Social Care Plans created for eligible Medicaid Managed Care Members will be a reported requirement to OHIP as required within the SCN's Monthly Performance Metrics.

SCN Lead Entities are responsible to ensure 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.

ii. Components of a Social Care Plan

The SCN IT Platform will be required to automatically generate and save the Member's Social Care Plan. The Social Care Plan is intended to document an eligible Member's needs and why the HRSN service is needed. Any specifications for the HRSN should be included in the Social Care Plan as well as justification for the service.

The Social Care Plan will only be viewable by organizations contracted in the SCN and ecosystem partners that 1) are permitted under the data sharing agreement obtained during the Member Consent process and 2) received and accepted a Referral for the Member.

Select examples of details that may be included in the Social Care Plan could include (but are not limited to) are outlined in *Table 5-6* below.

Table 5-6: Select examples of details that may be included in a Social Care Plan for a Member in the Enhanced Services Population

Social Care Plan Component	Examples of details included in Member's Social Care Plan
General Member information	• Name of Social Care Navigator • Name and relationship of Members in the household, and any relevant HRSN services being received • Identification of which household Members are receiving Medicaid (Dependents are required to be included in the Social Care Plan, but others in the household are optional to include) • Name and relationship to Member of individual who completed the screening, if it was not the Member themselves • Current receipt of WIC, SNAP, and TANF • 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
Screening and navigation history	• Referring entity to SCN (if applicable) • Major life events requiring re-screening • Service coordination history (e.g., dates of assessments, names of case managers and providers) • Eligibility Assessment notes from health and social care professionals (e.g., documentation, existing federal services received)
HRSN service considerations	• 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) • Relevant social criteria for the Member to qualify for specific HRSN service (i.e., asthma, upcoming medical appointments, etc.)? • Details on HRSN Referral (e.g., specific organization, frequency, start / end dates, etc.) • Extension of services if applicable (e.g., additional six months of medically tailored meals)

	• Disenrollment and/or denial of service details
Close of service and Member satisfaction	• Documentation of close of service • Confirmation of if HRSN has been met and any additional Referrals • Documentation of satisfaction (e.g., meeting Member goals using SNOMED Goal codes)

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 HRSN services required to best address each eligible Member's unmet HRSNs.

Children that are developmentally capable of contributing to discussions with their Social Care Navigator during development of their Social Care Plan may be included in the discussions.

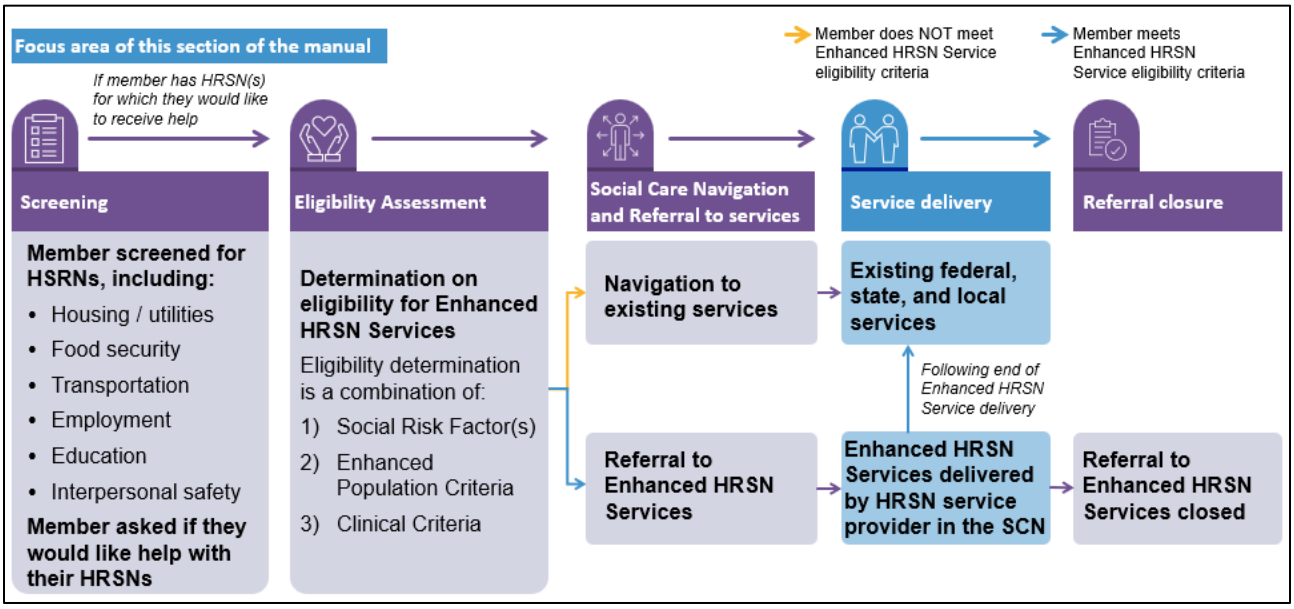
Additional details to include in Social Care Plans for children and youth

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

Coordinating with existing children and youth care plans: For all Members in an Enhanced Services 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 children- and youth-specific details do not need to be duplicated in the HRSN Social Care Plan as long as this information is appropriately documented in the SCN IT Platform.

i. 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 services 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 will be authorized for up to six months. Medically tailored or medically appropriate meals are able to be reauthorized for an additional six months if the MCO determines that the individual still meets the clinical and needs-based criteria. Select Nutrition services may be authorized for up to 11 months for high-risk pregnancies, and not to exceed two months postpartum. Other services are limited as noted below.

Care Navigation services will be available for the NYHER population on a continuum throughout and beyond the three-year 1115 Waiver contract period. In addition to helping to navigate Medicaid Members to the most appropriate HRSN services, Service 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 state, local, 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 5-7: Clinical and social risk criteria determined through the Eligibility Assessment

Component number	Component of eligibility determination[a]	Description	Source
1	Unmet HRSNs (Social Risk Factors)	Member must **screen positive for unmet HRSN(s)** on 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 Alignment	Member must **belong to one or more covered populations**, as assessed by criteria detailed below	Eligibility Assessment
3	Clinical Criteria	Member must **demonstrate medical necessity for individual Enhanced Services**, as assessed by clinical criteria 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 state and federal programs 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 not also doing Navigation
c. Determination of what services count as "duplicative" will be made by the SCN

OHIP will maintain the clinical and social risk criteria detailed above on a public-facing webpage and require that Social Care Networks also maintain these criteria 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.

ii. Covered Populations

The table below describes the covered populations (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.

Specific eligibility criteria are subject to change. Refer to www.health.ny.gov/mrt/sdh for the latest eligibility criteria.

Expectations for validation of clinical criteria, if any (i.e., for which criteria documentation will be required if not included in Enhanced Services Member File) will be shared at a later date.

Table 5-8: Enhanced Population Description

Populations are pending CMS approval

Enhanced Population	Population Description

Medicaid High Utilizer (adults and children)	• 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; or
	• Transitioned from one of the below institutional settings in the last 90 days and have a chronic condition, mental health condition, or physical disability:
	  ○ State Psychiatric
	  ○ Skilled Nursing Facility (SNF)
	  ○ State or Voluntary Community Residence
	  ○ Single Room Occupancy (SRO)
	  ○ Acute Care Hospital
	  ○ Large Group Homes
	  ○ Congregate Residential Settings

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, 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, sickle cell, or HIV/AIDS) 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)	An individual 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 (adults and children)	An individual 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 2 months post-partum. or Up to 12 months postpartum for high-risk members that meet at least one of the criteria listed under the New York State Prenatal Care risk factors (i.e. gestational diabetes, low birth weight, HIV/AIDS, etc.). Medicaid Perinatal Care Standards (ny.gov)

Enhanced Population	Population Description
Post-Release Criminal Justice-Involved Population with chronic conditions, SUD, or chronic Hepatitis-C	Members who have been released from incarceration within the last 90 days and have a chronic condition*, including substance use disorder and hepatitis C.

Juvenile Justice-Involved Youth; Foster Care Youth; or Those under Kinship Care	Members who:
	• Meet the criteria for juvenile-justice-involved youth or youth involved with child welfare:
	  ○ Juvenile-Justice-Involved Youth:
	  ○ Members 18 years and under released from incarceration within the past 12 months, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, New York Division of Juvenile Justice and Opportunities for Youth regional facilities, and tribal correctional facilities. Eligibility must be determined within 12 months of discharge
	  ○ Youth Involved with Child Welfare:
	  ○ Members 18 years and under who are currently or have been in the last 12 months
	  ○ In foster/substitute care;
	  ○ Receiving adoption or guardianship assistance or family preservation services; or
	  ○ The subject of an open child welfare case in any court;
	• And have, have a history of, or are at risk for at least one of the following:
	  ○ One or more chronic conditions (including mental health diagnosis and SUD),
	  ○ Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition,
	  ○ Child maltreatment as defined by the CDC,
	  ○ Is a child with a special healthcare need (CYSHCN) as defined by HRSA,
	  ○ Low birth weight of <2500 grams,
	  ○ Mental health condition,
	  ○ Significant life or family stress, adversity, or trauma

High-Risk Children under the Age of Six	Members under 6 who have, have a history of, or are at risk for at least one of the following: • A chronic condition, (e.g., mental health condition, developmental delay, allergies, physical disability, and asthma); • Overweight, obese, or underweight; • Behind on well-care visits per American Academy of pediatrics recommended schedule; • Ages 3-6 years not accessing dental care (at least 1 visit in the past 12 months); • Emergency Department visit within past 12 months; • Hospital inpatient admission within past 12 months; • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition; • Child maltreatment as defined by the CDC;

Enhanced Population	Population Description
	• Is a child with a special healthcare need (CYSHCN) as defined by HRSA; • Low birth weight of <2500 grams; • Mental health condition; or • Significant life or family stress, adversity, or trauma.
Children under the Age of 18 with one or more chronic conditions, including mental health conditions	Members under 18 who have, have a history of, or are at risk for at least one of the following: • A chronic condition, (e.g., mental health condition, developmental delay, allergies, physical disability, and asthma); • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition; • Child maltreatment as defined by the CDC; • Is a child with a special healthcare need (CYSHCN) as defined by HRSA; • Low birth weight of <2500 grams; • Mental health condition; or • Significant life or family stress, adversity, or trauma

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

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 positive unmet need response from the Member's screening results, the Social Care Navigator must assess the related Social Risk Factor (*Table 5-9*).

Table 5-9: Social Risk Factors

AHC HRSN Screening Tool Question and Related Positive 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). 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.
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
Nutrition: *Within the past 12 months, you worried that your*	Nutrition related need	An individual who screens often true or sometimes true to the nutrition questions on the

food would run out before you got money to buy more. • Often true • Sometimes true		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.
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: • 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. Clinical Criteria

Appropriate Enhanced HRSN Services for the Enhanced Population with identified social risk factors will be determined using clinical criteria *(Table 5-10)*.

Table 5-10: Clinical Criteria

Clinical criteria pending CMS approval

Service	Eligible Population	Social Risk Factor	Clinical Criteria
1) Care Management			
1.1 Navigation services	All Medicaid	Enrolled in Medicaid and screens as having an unmet need using the AHC HRSN Screening Tool	N/A
1.2 Enhanced HRSN Services	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s)	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with at least one chronic condition
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,	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities domain	• Physical disability that limits independence • Documentation from Member's provider attesting to medical necessity

Service	Eligible Population	Social Risk Factor	Clinical Criteria
bathroom facilities, kitchen cabinet or sinks, non-skid surfaces			
2.2a Medically necessary home remediation services: mold / pest remediation.	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities domain	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
2.2b Medically necessary home remediation services: repairing or improving ventilation systems, air conditioners, heaters, humidifiers, dehumidifier	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities domain	• 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) • High risk children under the age of six • Pregnant and Postpartum Persons • Individuals with Intellectual and Developmental Disabilities • 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

Service	Eligible Population	Social Risk Factor	Clinical Criteria
			foot, or chilblains) requiring emergency room or urgent care visit within last 12 months that occurred at home. • Individuals with Substance Use Disorder • Individuals with Serious Mental Illness • Individuals regularly taking medications or have an otherwise stated condition that interferes with daily thermoregulation
2.2c Medically necessary home remediation services, refrigeration units as needed for medical treatment	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities and/or food insecurity domain	• 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
2.3 Asthma Remediation	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities domain	Service is restricted to the Enhanced Services Population that has a diagnosis of asthma and has had: • 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
2.4 Medical Respite (Recuperative Care) - Pre and Post Hospitalization	All Enhanced Populations	• An individual who screens positive for and is assessed to have unmet HRSN(s) under	Service is restricted to individuals that are:

Service	Eligible Population	Social Risk Factor	Clinical Criteria
		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	• Requiring pre-surgical or procedure care as indicated by a medical professional, **or** • Transitioning out of institutions, including acute care hospitals, **and** • At risk for incurring other Medicaid state plan services, such as inpatient hospitalization or Emergency Department visits, **and** • Requiring recuperation and care for an illness or injury.
2.5 Rent / Temporary Housing for up to six months	All Enhanced Populations	• An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities domain	Service is restricted 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, and acute care hospitals within the past 90 days; or • Individuals who are homeless as defined by 24 CFR 91.5; or • Youth transitioning out of the child welfare system including foster care
2.6 Utility Setup / Assistance	Limited to those receiving Rent / Temporary housing	• An individual who screens positive for and is assessed to have unmet HRSN(s) under housing / utilities domain; and • Receiving Rent / Temporary Housing for up to 6 months	Service is restricted 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, and acute care hospitals within the past 90 days; or • Individuals who are homeless as defined by 24 CFR 91.5; or

Service	Eligible Population	Social Risk Factor	Clinical Criteria
			• Youth transitioning out of the child welfare system including foster care
2.7 Pre-tenancy services	All Enhanced Populations	• An individual who screens positive for and is 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.	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six Children under the age of 18 with one or more chronic condition
2.8 Community Transitional Services	All Enhanced Populations	• An individual who screens positive for and is 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.	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
2.9 Tenancy sustaining services	All Enhanced Populations	• An individual who screens positive for and is assessed to	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program

Service	Eligible Population	Social Risk Factor	Clinical Criteria
		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.	• Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
2.10 Housing Transition and Navigation Services	All Enhanced Populations	• An individual who screens positive for and is 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.	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
3) Nutrition			
3.1 Nutritional Counseling and Education	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under food security domain	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities

Service	Eligible Population	Social Risk Factor	Clinical Criteria
			• Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
3.2 Medically Tailored or clinically appropriate meals	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under food security domain	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under food security domain	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic

Service	Eligible Population	Social Risk Factor	Clinical Criteria
			condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under food security domain	Service is restricted to individuals that are: • Pregnant and postpartum persons • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
3.5 Cooking Supplies	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under food security domain	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI • Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition
4) Transportation Services			
Transportation related to HRSN service or care management	All Enhanced Populations	An individual who screens positive for and is assessed to have unmet HRSN(s) under transportation and	• Medicaid High Utilizers • Enrolled in a NYS-designated Health Home Program • Individuals with SUD • Individuals with SMI

Service	Eligible Population	Social Risk Factor	Clinical Criteria
		needs transportation assistance to assess HRSN and/or care management activities. An unmet need includes: ○ 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.	• Individuals with Intellectual and Developmental Disabilities • Pregnant and Postpartum Persons • Post-release criminal justice within the last 90 days and have a serious chronic condition, including substance use disorder and hepatitis C • Juvenile justice involved youth, foster care youth, and those under kinship care • High-risk children under the age of six • Children under the age of 18 with one or more chronic condition

v. Covered HRSN Services

Additional details regarding the covered HRSN services 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 5-11: HRSN services included in the SCN program

HRSN Category	Enhanced HRSN Service
Care management	1.1 Navigation Services
	1.2 Enhanced HRSN Care Management (population eligible for Enhanced HRSN Services)
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
	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
	3.2 Medically Tailored or 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, care coordination, 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.

Care Management for either Navigation services or Enhanced HRSN Services will begin immediately by the SCN for any Medicaid Member that screens positive to any of the questions on the AHC HRSN Screening Tool.

1.1 **Navigation Services**

Medicaid FFS Members who screen positive for an unmet HRSN and Medicaid Managed Care Members who screen positive for an unmet HRSN but are ineligible for Enhanced HRSN Services may be eligible for Navigation to existing federal, state, and local benefits and programs. Members in the Navigation population will not receive access to Enhanced HRSN Services funded under the 1115 Waiver.

Table 5-12: Navigation eligibility and service details

Navigation eligibility and service details	
Eligibility	1. Medicaid FFS Members who screen positive for unmet HRSN; or 2. Medicaid Managed Care Members who screen positive for unmet HRSN but do not meet the criteria for populations eligible for Enhanced HRSN Services
Service Limitations and Restrictions	Medicaid Members may access Navigation upon one annual screening (or re-screening due to a major life event) for Referral assistance to federal, state, or local services during the demonstration period
Allowable Providers	• Social Care Navigators may include employees of the SCN Lead Entity or networked HRSN service providers • Entities providing Navigation should have experience assisting underserved populations with connection to services • Entities providing Navigation should have training related to HRSN screening and doing so in a linguistic and culturally appropriate manner

1.2 **Enhanced HRSN Services Care Management (Enhanced Services Population eligible for Enhanced HRSN Services)**

For the NYHER population eligible for Enhanced HRSN Services, the Social Care Navigator has the responsibility of providing outreach, Eligibility Assessment, Referral management, care coordination, education and confirms with the Member whether the Referral was accessed, and whether their needs were met. Social Care Navigators will coordinate if applicable, the Member's benefit program application assistance and provide connection to clinical care management.

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.

Table 5-13: 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 5-9
Service Limitations and Restrictions	1. Care Management may be a standalone service, without a Member receiving services in any other Enhanced HRSN Services domain 2. Members may be engaged in multiple services under Care Management as long as the total cost is at or below the aggregate service cap as outlined in the HRSN Service Fee Schedule 3. SCNs will provide Care Management related to HRSNs only and will not provide any clinical Care Management
Allowable Providers	• Social Care Navigators may include employees of the SCN Lead Entity or of organizations that are contracted as part of the Network • HRSN service providers should have experience connecting underserved populations to services • HRSN service providers must participate in trainings to ensure that HRSN screenings are conducted in a linguistic and culturally appropriate manner

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 Navigator may refer Members to existing services.

Additional questions support to understand eligibility for specific Enhanced HRSN Services

Table 5-14: Housing / Utilities screening questions

Housing / Utilities Screening	
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**

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. 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.

These services are available for a home that is owned, rented, leased, or occupied by the Medicaid Member or their caregiver. For a home that is not owned by the Member or their caregiver, written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, ramps, etc.) will be required. A review of the qualified Medicaid Member's primary residence should be conducted to determine the physical adaptions and modifications necessary to ensure maximum health, welfare, and safety, or to allow the Member to function independently in their home. Outcome of home review and recommended services must be documented in the Social Care Plan and approved by the SCN. The Member's Social Care Plan should include the approved and completed services.

Table 5-15: 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 5-8 and Social Risk Factors in Table 5-9; 2. Meets the clinical criteria in Table 5-10; and 3. Is determined to have a need for modification and remediation services to increase and/or improve home accessibility and safety by a Navigator.
Service Limitations and Restrictions	1. If applicable, SCNs 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.
Allowable Providers	• Contracted Home modification HRSN service providers that are designated as a non-profit Community Based Organization 501 (c)(3) or 501(c)(4) • 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*) • Service providers should have knowledge and experience with providing related home accessibility and safety modifications. • Either the SCN or a contracted organization that is part of the Network can contract with the remediation / ventilation company • Modifications must be conducted in accordance with applicable state and local building codes

Workflow for Home Accessibility / Safety Modification Service

The SCN will need to create a unique workflow for the Home Accessibility / Safety Modification Service based on the home environment assessment which includes their Statement of Work (SOW). In general, the workflow should follow the below steps:

- MCO sends Enhanced Services Member File to NYeC/SHIN-NY data lake that includes any associated clinical criteria or social risk factors
- QE receives the Enhanced Services Member File
- QE sends the Enhanced Services Member File to the appropriate regional SCN Lead Entity
- Social Care Navigator(s) conducts screening, and Eligibility Assessment with the Member
- SCN records in the Social Care Plan what Enhanced HRSN Services the Member is eligible for, any new clinical or social risk criteria required for Enhanced HRSN Services, and all other relevant questions related to Social Care Plan as listed in Section 8, "Care Plan Based on Eligibility Assessment"
- If the Member is eligible for Home Accessibility / Safety Modification service, the SCN will proceed with assigning the appropriate ICD/SNOMED code which will trigger a Referral for the SCN to select a contracted Network organization for a home environment assessment
- The contracted Network organization will accept or decline the Referral

- If the contracted Network organization accepts the Referral, it will contact the Member to perform an in-person home environment assessment and will report the recommended Enhanced HRSN Services back to the SCN Lead Entity within a Statement of Work (SOW)
- The SCN reviews the SOW and selects the appropriate services to authorize. (Note: contracted Network organization may suggest services that are not covered under the Enhanced HRSN Services and SCN will need to authorize only the approved Enhanced HRSN Services)***
- The SCN obtains written consent if the Member agrees to the services authorized in the SOW and obtains if necessary written consent from the landlord also
- The SCN documents the authorized contracted Network organization services within the Social Care Plan
- The contracted Network organization proceeds with rendering the approved Enhanced HRSN Services and updates the SCN IT Platform to demonstrate the services have been rendered
- The SCN documents the completed services within the Social Care Plan and follows up with the Member within a reasonable timeframe to document their satisfaction and if their goals were successfully met
- The SCN proceeds with issuing a completed Social Care Claim to the MCO for completed service for tracking purposes
- The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the HRSN service provider on a fee schedule-based reimbursement basis

***Physical modification done by a licensed contractor should follow the OMB circular A-122 of obtaining invoices for anything over $1,000.

2.2 Home Remediation Service

Home remediation services are limited to repairs or remediations to an eligible Member's 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.

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 repairs or improvement of ventilation systems. May include provisions of devices and appliances that are eligible by clinical criteria:

- Air conditioners;

- Humidifiers;
- Dehumidifiers;
- Heaters;
- Air filtration devices.

2.2c Equipment Provision

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

These services and provisions are available in a home that is owned, rented, leased, or occupied by the eligible Medicaid Member or their caregiver. For a home that is not owned by the Member or their caregiver, written consent from the owner for physical repairs or remediation to the home will be required. A review of the qualified Medicaid Member's primary residence should be conducted to determine the home remediation services or provisions necessary to ensure maximum health, welfare, and safety. Outcome of home review and recommended services must be documented in the Social Care Plan and approved by the SCN.

Table 5-16: Home Remediation: 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 5-8 and Social Risk Factors in Table 5-9; 2. Meets the clinical criteria in Table 5-10; and 3. 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
Service Limitations and Restrictions	1. SCN must document the qualifying clinical criteria (Table 5) for Home Remediation 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
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 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

Workflow for Home Remediation Service

The SCN will need to create a unique workflow for the Home Remediation Service due to the HRSN service provider's home environment assessment which includes their Statement of Work (SOW). In general, the workflow should follow the below steps:

1. MCO sends Enhanced Services Member File to NYeC/SHIN-NY data lake that includes any associated clinical criteria or social risk factors
2. QE receives the Enhanced Services Member File
3. QE sends the Enhanced Services Member File to the appropriate regional SCN
4. Social Care Navigator(s) conducts screening, and Eligibility Assessment with the Member
5. Social Care Navigator records in the Social Care Plan which Enhanced HRSN Service the Member is eligible for, any new social risk factors and clinical criteria for Enhanced HRSN Services, and any other relevant Eligibility Assessment guidance to inform the Social Care Plan (see Social Care Plans section).
6. If the Member is eligible for Home Remediation / Modification service, the Social Care Navigator will proceed with assigning the appropriate ICD/SNOMED code which will trigger a Referral for the SCN to select an organization in the Network to conduct a home environment assessment
7. The Network organization will accept or decline the Referral
8. If the Network organization accepts the Referral, the organization will contact the Member to perform an in-person home environment assessment and will report the recommended Enhanced HRSN Services back to the Social Care Navigator. The Social Care Navigator reviews the SOW and selects the appropriate services to authorize. (Note: Network organization may suggest services that are not covered under the Enhanced HRSN Services)***
9. The Social Care Navigator obtains written consent if the Member agrees to the services authorized in the SOW and obtains if necessary written consent from the landlord The Social Care Navigator documents the authorized services within the Social Care Plan
10. The Network organization proceeds with rendering the approved Enhanced HRSN Services and updates the SCN IT Platform to demonstrate the services have been rendered
11. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the Member within a reasonable timeframe to document their satisfaction and if their goals were successfully met
12. The Social Care Navigator proceeds with issuing a completed Social Care Claim to the MCO for completed service for tracking purposes
13. The Social Care Navigator proceeds with issuing reimbursement (from PMPM payments) to the HRSN service provider on a fee schedule-based reimbursement basis

*****Physical modification done by a licensed contractor should follow the OMB circular A-122 of obtaining invoices for anything over $1,000.**

2.3 Asthma Remediation

Remediation services will be available to Enhanced Population Members with a diagnosis of asthma and meet the clinical criteria in Table 5. Asthma remediation services will 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 may address multiple triggers to improve the home environment and Member's capacity for asthma self-management. Asthma remediation services will include the following components:

a. 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 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 (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. A minimum of two ASME visits (initial and final) must be conducted face-to-face in the primary residence(s) of the recipient, over the phone, or virtually.

- **Specifications for each visit are as follows:**
    - **Initial Visit:** must be conducted in-person 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.
    - **Final Visit:** may be conducted in-person in the Member's dwelling, virtually face-to-face, or over the phone and must be no earlier than 45 days post completion of all home remediation, to determine changes in asthma control status by administrating and scoring a validated, age-appropriate asthma control screening questionnaire (ACT, C-ACT, TRACK), reinforce education, report Member's progress and improvements in the home environment.

The SCN should make Referrals if necessary for the Member or their family if applicable before the Asthma Remediation service duration period ends.

b. Home Environment Assessment & Determination of Scope of Work (SOW): a comprehensive review of the primary residence to identify home remediations needed to reduce or eliminate asthma triggers and improve the indoor environment of the dwelling. The SOW should be developed by a qualified home improvement contractor, incorporate results and relevant findings from the home environment assessment, and be approved by the SCN. Written consent must be obtained from the Member and the landlord for installation work to be performed in a rented dwelling.

c. Home Remediation and Provision of Supportive Products: Remediation services and supportive products will be limited to those listed in the table below and must be authorized by the SCN prior to being

provided. Installation services may address ventilation and air quality, removal of asthma triggers, and Integrated Pest Management (IPM) in alignment with the approved SOW.

Table 5-17: 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 • 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 • Gas stove removal and replacement with an electric or induction stove	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) • Sum pump repair / replacement • Carpet removal or removal of moldy wet flooring and installation of Asthma-friendly flooring • Dirt floor vapor barrier basement / crawlspace • Roof repair • Cleaning / repair / installation of gutter downspout system and gutter screens • *Mold remediation (less than 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 • 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."*

If determined to be needed on a Home Environment Assessment, the following services will be available under other Enhanced HRSN Service titles:

Home Accessibility and Safety Modifications: Air conditioners, humidifiers and air filtration devices will be available to eligible Members.

Table 5-18: 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 5-8 and Social Risk Factors in Table 5-9; 2. Meets the clinical criteria in Table 5-10; 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. SCN must document the qualifying clinical criteria for asthma remediation 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. Services requiring invasive measures will require written approval from property owner (landlord, if the home is rented) 5. Medicaid Managed Care Member must be a resident of a single-family or multi-unit primary residence owned or rented by a primary caregiver or by oneself
Allowable Providers	• Contracted asthma remediation service providers that are designated as a non-profit Community Based Organization 501 (c)(3) or 501(c)(4) • Contracted Asthma Remediation service providers 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. See *HRSN Network Capacity and Access* section for details

	• Asthma Self-Management Education (ASME) must be provided by a qualified nonphysician health care professional 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 home improvement contractors must have demonstrated experience providing home installation improvement services for environmental trigger reduction and expanded health and safety measures such as: ventilation, mold remediation, and IPM – as well as experience identifying and remediating asthma-related home environmental triggers. Asthma remediation that is a physical adaptation to a residence must be performed by an individual holding a New York State Contractor's License. IPM should be delivered by professionals licensed by the NYS Department of Environmental Conservation

Workflow for Asthma Remediation Service

The SCN will need to create a unique workflow for the Asthma Remediation Service due the CBO's home environment assessment and associated Statement of Work (SOW). In general, the workflow should follow the below steps:

1. MCO sends Enhanced Services Member File to NYeC/SHIN-NY data lake that includes any associated clinical criteria or social risk factors. This service will require indication of "Asthma"
2. QE receives the Enhanced Services Member File
3. QE sends the Enhanced Services Member File to the appropriate regional SCN
4. Social Care Navigator(s) conducts screening, and Eligibility Assessment with the Member.
5. The Social Care Navigator records in the Social Care Plan what Enhanced HRSN Services the Member is eligible for, any new clinical or social risk criteria required for Enhanced HRSN Services and all other relevant Eligibility Assessment questions related to Social Care Plan (see Social Care Plans section)
6. If the Member is eligible for the Asthma Remediation service, the Social Care Navigator will proceed with assigning the appropriate ICD 10 Z-Code/SNOMED code which will trigger a Referral for the Social Care Navigator to select a Networked organization for a home environment assessment
7. The Networked organization will accept or decline the Referral
8. If the Networked organization accepts the Referral, the HRSN service provider will contact the Member to perform an in-person home environment assessment and will report the recommended HRSN services back to the Social Care Navigator within a Statement of Work (SOW)
9. The Social Care Navigator reviews the SOW and selects the appropriate services to authorize. (Note: CBO may suggest services that are not covered under the Enhanced HRSN Services)***
10. The Social Care Navigator obtains written consent if the Member agrees to the services authorized in the SOW and obtains if necessary written consent from the landlord
11. The Social Care Navigator documents the authorized services within the Social Care Plan

12. The Networked organization proceeds with rendering the approved Enhanced HRSN Services and updates the SCN IT Platform to demonstrate the services have been rendered
13. The Networked organization providing services follows up with the Member between 30-45 days after Asthma Remediation services have been provided to administer an asthma control test to evaluate the impact before and after service competed
14. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the Member within a reasonable timeframe to document their satisfaction and if their goals were successfully met
15. The Social Care Navigator proceeds with issuing a completed Social Care Claim to the MCO for completed service for tracking purposes
16. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the HRSN service provider on a fee schedule-based reimbursement basis

*****Physical modification done by a licensed contractor should follow the OMB circular A-122 of obtaining invoices for anything over $1,000.**

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 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 1007) and program guidance. Certified MRPs must also offer transitional supports to help Members secure stable housing and avoid future hospital readmissions, coordinate with the SCN 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.

Recuperative care may be used as:

a. **Short-term Post Hospitalization Care** – provided to eligible Members transitioning out of institutions (i.e., acute care hospitals or skilled nursing facilities 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 5-19: 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 5-8 and Social Risk Factors in Table 5-9; 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	• Individual must be assessed for Medical Respite program eligibility and appropriateness in accordance with MR regulations and guidance • Post-hospitalization recuperative care may be offered for up to ninety (90) days in duration once every 12 months (assessed on a rolling basis) • Pre-procedure stays are limited to a clinically appropriate amount of time as determined by medical professional • The combination of pre-procedure and post-hospitalization housing may not exceed 6 months, within each 12-month period • 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 1007) and relevant program guidance
Allowable Providers	• State-certified Medical Respite providers who are contracted with the SCN

Workflow for Medical Respite Service

The SCN will need to create a unique workflow for the contracted Medical Respite provider due to the requirements of (1) The Member will first have an Eligibility Assessment with the SCN and (2) The eligible Member will have a secondary Assessment conducted by the Medical Respite facility in accordance with their regulatory requirements. 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, and HRSN service providers will either screen a Member in their care, complete an Eligibility Assessment and then send a Referral to the SCN Lead Entity; **OR**

2. Hospitals, Clinics, HRSN service providers, and ecosystem partners may send the Member's Referral for Medical Respite services directly to the regional SCN (without screening or Eligibility Assessment) – ******See Details below for Direct Referrals to the SCN***;

3. The regional SCN will conduct screening and Eligibility Assessment with the Member (if not already completed by the referring entity)

- If the SCN discovers any new qualifying eligibility criteria found during an Eligibility Assessment that will help the Member become eligible for Medical Respite or other Enhanced HRSN

Services, the SCN will outreach the MCO to add Member follow-up to MCO Enhanced Services Member File

4. Based on the SCN's Eligibility Assessment the SCN's Social Care Navigator will either:

a. Reject the Referral if the Member does not meet NYHER eligibility criteria. The SCN IT Platform will have the ability of recording the rejection as coming from the SCN. The SCN will outreach the referring entity via the SCN IT Platform with an indication of Referral rejection **AND** provide verbal and written notification to the referring entity on outcome of Referral **OR;**

b. Accept the Referral if the Member meets NYHER eligibility criteria. The SCN will refer the Member to a local contracted Medical Respite Provider for the Medical Respite to conduct their regulatory Assessment which may be in person for pre and post hospital care service in accordance with the NYS established regulations and Medical Respite program guidance

5. Based on the Medical Respite Programs (MRP) Regulatory Assessment, the Medical Respite will either:

a. Reject the SCN's Referral. If the MRP rejects the SCN's Referral (due to capacity, individual is not appropriate for facility, etc.), the SCN will either outreach another MRP that may accept the Member or when attempts have been exhausted, notify the referring entity of the unsuccessful attempts to find an appropriate MRP via the SCN IT Platform **AND** provide verbal and written notification of the rejection. The SCN IT Platform will have the ability of recording the rejection as coming from the MRP; **OR**

b. Accept the SCN's Referral. If the MRP accepts the Member's Referral, they will proceed with SCN IT Platform requirements to accept the SCN's Referral request

6.The SCN notifies the referring entity that the MRP accepts the Referral

7. The SCN documents the authorized Medical Respite 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 HRSN services

8.The Medical Respite proceeds with rendering their services in the SCN IT Platform, documents relevant notes into the SCN Social Care Plan including estimated discharge date

9. The SCN documents the completed services within the Social Care Plan and follows up with the Member / Medical Respite to document the Member's satisfaction if their goals were successfully met and offer assistance and coordination with the Medical Respite to provide additional transitional HRSN services prior to the discharge date (where the Member qualifies for additional Enhanced HRSN Services)

10. The SCN proceeds with issuing a completed Social Care Claim to the MCO for completed service (for tracking purposes only)

11. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the Medical Respite on a fee schedule-based reimbursement basis

*****Direct Referrals to the SCN (additional details from #2 in workflow above)**

Referring entities (Hospitals, clinics, etc.) may send Referrals directly to the SCN for consideration of coverage through the 1115 Waiver. The SCN will not be determining the units or length of stay for the Member, this will be the determination of the Medical Respite. The service units within the Referral will be empty and once the Medical Respite confirms, the SCN or the Medical Respite will enter within the SCN IT Platform. The SCN will review and approve or reject the unit / length of stay recommendation. SCN's should prioritize Medical Respite Referrals and strive for a rapid turnaround of **2 business days** to assign a Medical Respite program and issue the Referral.

If the Member does not meet 1115 criteria for eligibility, the SCN will send the Referral back to referring entity who will reach out directly to a Medical Respite.

Referring entities may also send Referrals directly to the Medical Respite with documentation required within the Member's medical records.

The clinical criteria required per NYHER are to be sourced from the referring entity's Referral package, and will not be assessed by the Social Care Navigator. A Referral from originating entity (e.g., hospitals, clinics, etc.) to SCN 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:
    - Requiring pre-surgical or procedure care as indicated by a medical professional and recommended length of stay, **or**
    - Transitioning out of institutions, including acute care hospitals, **and**
    - At risk for incurring other Medicaid state plan services, such as inpatient hospitalization or Emergency Department visits, **and**
    - Requiring recuperation and care for an illness or injury and recommended length of stay

- **Medical orders and Medical records** should be coordinated between referring entity and the Medical Respite directly, as SCNs may not receive documentation
    - **Medical orders** (coming from original referring entity, not the SCN) for items that the individual will need for recuperation, such as:
        1. 30-day supply of medication(s), either by submitting prescription(s) to a pharmacy or arranging to transfer the medication(s) with the recipient;
        2. Home health care service orders (if applicable); and
        3. Durable medical equipment or other supplies

- **Medical records** that address:
    1. The individual's diagnosis;
    2. Pertinent medical history;
    3. Results of diagnostic tests or screenings; and
    4. Current or recommended interventions, including post-acute care and medications
- **Eligibility Assessment of individual to receive medical respite services**. The results of the Eligibility Assessment 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:
    1. 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;
    2. Description of the individual's physical limitations, if applicable, and any reasonable accommodations that may be required of the medical respite program;
    3. Confirmation that the individual can perform ADLs with no or minimal assistance *or* provision of a physician order for certified home health agency services;
    4. 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; and
    5. Confirmation that the individual is not, at the time of Referral, a threat of harm to their self or others

2.5 **Rent / Temporary Housing**

Rent / Temporary Housing includes payment for rent and/or short-term, temporary stays for up to six months, including 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, motel or hotel when it is serving as the Member's primary residence, transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming.

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, storage fees, renters insurance, landlord-paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments).

Table 5-20: Rent / Temporary Housing: 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 5-8 and Social Risk Factors in Table 5-9 and 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	1. Rent / temporary housing services are limited to up to six months. The SCN 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. SCN must document the qualifying clinical criteria for Rent / Temporary Housing in the Member's Social Care Plan (e.g., transitioning from institution, etc.) 3. Rent / temporary housing services are limited to those eligible Members who are willing and capable of living safely within community with appropriate and cost-effective support services. SCNs must document this in the eligible Member's Social Care Plan
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 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) 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**

Qualified Medicaid Members receiving rent and temporary housing per Section 2.5 for rent / temporary housing above may also be eligible for assistance with setting up utility services in their new community living setting. Utility setup and assistance services may include activation costs and back payments to secure utilities, and payment of up to six (6) months of utility costs in combined back/prospective payments.

Utility costs are limited to households receiving rent assistance / temporary housing and are available for up to six months. This service provides payment for recurring utilities and non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills. The combination of arrears payments and prospective payments for utilities cannot exceed 6 months.

This service will cover expenses for the following types of utility payments:

- Garbage
- Water
- Sewage
- Recycling
- Gas
- Electric
- Internet
- Phone (inclusive of landline phone service and cell phone service)

Table 5-21: 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 5-8 and Social Risk Factors in Table 5-9 2. Meets the clinical criteria in Table 5-10 3. Must be receiving rent / temporary housing services as described in Section 2.5 on rent / temporary housing
Service Limitations and Restrictions	1. Utility Setup / Assistance is limited to up to 6 months in total back/prospective payments and 2. Utility Setup / Assistance is limited to individuals receiving rent / temporary housing services as outlined in Section 2.5
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'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

Medicaid Managed Care Members may qualify for pre-tenancy services under this 1115 Waiver authority, including:

- Support during tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews;
- Assistance with the set-up of the new housing unit, to address needs identified in the person-centered Social Care Plan for eligible Members, including clinically appropriate residential modifications to allow the Member to move in and identified 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 resources for assistance with rental assistance vouchers, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, food and clothing needed at transition, and other related expenses; and
- Review of the living environment to ensure that it meets the clinical needs of the individual and appropriately supports any identified social risk factor. This review should confirm the environment is ready for move-in and include 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 5-22: Pre-tenancy: 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 5-8 and Social Risk Factors in Table 5-9 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	1. Services are limited to no more than six months, with the exception of housing navigation
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'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. The following one-time transition and moving costs are included:

- Security deposit, first month's rent, 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 (pots and pans, bed, mattress, lamps, nightstands, etc.)

Table 5-23: Community Transitional Supports (CTS): eligibility and service details

Community Transitional Supports (CTS): eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-8 and Social Risk Factors in Table 5-9 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	1. Service is a one-time expense and does not continue after the individual is stably housed
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'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. 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 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; and
- Assistance with housing recertification processes, including lease renewals and housing subsidy renewals

Table 5-24: Tenancy Sustaining: eligibility and service details

Tenancy Sustaining: eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-8 and Social Risk Factors in Table 5-9 2. Meets the clinical criteria in Table 5-10
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'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 the complexities of the housing search and application process. Under this 1115 Waiver authority, housing transition and navigation services will include:

- 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

Table 5-25: 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 5-8 and social risk factors in Table 5-9 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	1. Services are capped at 6 hours per month for the duration of the Waiver period
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'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

Nutrition Supports

The NYS 1115 Waiver makes available several nutrition support services to meet the enrolled 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) or SNAP (OTDA) through Care Management services.

MLTCP and MAP Members are not eligible for 1115 Waiver nutrition services since they are provided by the plans. High-risk pregnant and children are eligible for addition nutrition supports where indicated.

Table 5-26: Food Security Screening questions

Food Security Screening	
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
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

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, 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. Nutritional Counseling and Education include individual or group:

- Assessment of nutritional needs and food patterns;
- Planning for and directing the provision of food appropriate for physical and nutritional needs;
- Nutrition Counseling; and
- Meal preparation and grocery shopping education

Table 5-27: 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 5-8 and Social Risk Factors in Table 5-9 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	1. Nutritional counseling and education must be approved by Certified Dietitian / Nutritionists and be evidence-informed and 2. Be provided in accordance with evidence-based nutrition guidelines
Allowable Providers	1. Certified Dietitian / Nutritionists or registered nurse dietician 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

3.2 **Medically Tailored or Clinically Appropriate Home Delivered Meals**

Home delivered prepared medically tailored or clinically appropriate meals will be available to Medicaid Managed Care Members who screen positive for food insecurity 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.

Table 5-28: Medically Tailored or Clinically Appropriate Home Delivered Meals: eligibility and service details

Medically Tailored or Clinically Appropriate Home Delivered Meals: eligibility and service details	
Eligibility	1. Meets at least one of the criteria for Enhanced HRSN Services in Table 5-8 and Social Risk Factor in Table 5-9 2. Meets the additional clinical criteria in Table 5-10
Service Limitations and Restrictions	1. This service is limited to three (3) prepared meals a day for up to 6 months at a time 2. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 2 months postpartum, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household. 3. Additional meal support is only permitted when provided to the household of a child or pregnant member meeting criteria in Table 5-8. 4. Meals can only be delivered to the enrolled Member's home or private residence 5. Members who receive home delivered medically tailored or clinically appropriate meals cannot also receive Pantry Stocking (Fresh Produce and Non-perishable Groceries) or Medically Tailored / Nutritionally Appropriate Food Prescription
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'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

3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions

Medicaid Managed Care Members who screen positive for food insecurity and meet eligibility criteria may be eligible for medically tailored or nutritionally appropriate food prescription. 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 be redeemed at food pharmacies, farmer's markets, mobile markets, and Community Supported Agriculture (CSA) subscriptions. Members who opt for food boxes will receive a weekly delivery of fruits, vegetables, and protein boxes.

1. Food Boxes

Food boxes will include enough delivered items to create an estimated 7 meals per week. This will also serve as a recommended portion control.

2. Nutrition Vouchers

Vouchers will have a stated dollar amount and will serve to nutritionally supplement meals at an estimated quantity of 7 nutritional items per week.

Table 5-29: 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 5-8 and social risk factors in Table 5-9 and 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	1. This service is limited to weekly delivery of fruit and vegetable prescriptions, and protein boxes 2. This service is limited to three (3) prepared meals a day for up to 6 months at a time 3. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 2 months postpartum, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent

	pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household. 4. Additional meal support is only permitted when provided to the household of a child or pregnant member meeting criteria in Table 5-8. 5. Meals can only be delivered to the enrolled Member's home or private residence 6. 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 (MTM)
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'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

3.4 **Fresh Produce and Non-perishable Groceries (Pantry Stocking)**

Medicaid Managed Care Members who screen positive for food insecurity, 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. Provision of this service is limited to children under age 18 and pregnant persons, for up to six months. Pregnant individuals, as defined in Table 5-8, may receive up to 11 months of fresh produce and non-perishable groceries (pantry stocking).

Fresh Produce and Non-perishable Groceries will serve to nutritionally supplement meals at an estimated quantity produce to produce 7 meals per week.

Table 5-30: 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 5-8 and social risk factors in Table 5-9 and 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	• Pantry stocking service is limited to children under age 18 and pregnant individuals who qualify under criteria in Table 5-8

	• Pantry stocking services are provided six months at a time. Services may be renewed if a qualified Member still meets the clinical and needs-based criteria above, as determined by the SCN • If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 2 months postpartum, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household. • 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 Deliver Meals
Allowable Providers	• Contracted Pantry Stocking service providers that are designated as a non-profit Community Based Organization 501(c)(3) • Contracted Pantry Stocking services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) CBO. (*See HRSN Network Capacity and Access section for details).* 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 Members who screen positive for food insecurity may qualify for cooking supplies that are necessary for meal preparation and nutritional welfare when not available through other programs (e.g., pots and pans, utensils, microwave, refrigerator). The refrigerator listed in this section is independent from the medical refrigerator available under Housing Service.

Table 5-31: 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 5-8 and social risk factors in Table 5-9 and 2. Meets the clinical criteria in Table 5-10

Service Limitations and Restrictions	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
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'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 meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

Transportation

4.1 Transportation Services

Transportation services may be available to eligible Medicaid Managed Care Members that screen positive for an HRSN and meet the social risk factors and clinical criteria required for Enhanced HRSN Service under this 11115 Waiver.

Table 5-32: Transportation Screening questions

Transportation Screening	
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., Uber, Taxi, Lyft, bus or train pass) 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.

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;
- Employment interviews;
- 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.

Table 5-33: 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 5-8 and Social Risk Factors in Table 5-9 and 2. Meets the clinical criteria in Table 5-10
Service Limitations and Restrictions	• Transportation services are not the same as Medicaid transportation and are not tied to it in any way • Transportation services may only be used for activities related to accessing Enhanced HRSN Services and/or care management services • Transportation is a limited service and should only be used when there are no other transportation options for the member • Transportation services may be provided to a qualified Member's caregiver or guardian for the direct benefit of the Member
Allowable Providers	• Contracted Transportation service providers that are designated as a non-profit Community Based Organization 501(c)(3). • Contracted Transportation services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization. (*See HRSN Network Capacity and Access section for details).*

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 5-34: 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

j. 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 SCN 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 / post-partum 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, 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.

SCNs 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 screens positive for at least one unmet HRSN. Existing services will not receive any 1115 Waiver funding for providing their services. The SCN 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 to monitor and report to OHIP the connection to existing services and ensure the Member has successful accessed the existing programs for services.

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:

- SNAP (OTDA)
- WIC (DOH)

- TANF (OTDA)
- HEAP (OTDA)
- Local, state, and federal housing
- Vital partnerships

ii. Statewide Health Equity Regional Organization (SHERO)

OHIP contracted SHERO will be charged with bringing stakeholders together to collaboratively support and augment data governance, data management, regional needs, assessment, and planning, VBP design and development, and program evaluation.

The SCN Lead Entities will each remain an independent entity that will participate with the SHERO but are not overseen by the SHERO.

iii. Proactive Member Screening outreach strategies

SCNs are expected to develop approaches to conduct proactive outreach to Members for screening to maximize the number of individuals screened. 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 healthcare 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 and
- **Community Outreach Strategy:** Developing an outreach strategy in collaboration with organizations in the Network to reach embers in neighborhoods identified as having health disparities to encourage HRSN screening

k. 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. OHIP will provide SCNs the final language for Question 0: Consent. OHIP is considering the language below:

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 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.

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.*

ii. Member Consent for Eligibility Assessment

Following a positive screen, 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.

OHIP is considering the following language prior to assessments. At a minimum, verbal affirmation from a Member is required to proceed with use of their health data. OHIP will develop simple and short language for use in written forms. 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.

DRAFT – 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?

OHIP will work collaboratively with SCNs to ensure that consent is captured before the Member's assessment and that Member education for consent is streamlined with other Member education. OHIP will consider a standardized consent document.

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?

I. DUPLICATIVE SERVICES

OHIP expects that services delivered by SCNs will be incremental to – rather than duplicative of – services that are already received by Members, including but not limited to existing state and federal programs and ILOS provided by MCOs. SCNs will work with MCOs and Members to ensure that services are not duplicative.

6. PERFORMANCE

Performance and payment sub-sections:

a. Overall Approach to Performance Management

b. SCN Lead Entity Reporting

c. Member Satisfaction

a. OVERALL APPROACH TO PERFORMANCE MANGEMENT

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 the "SCN Reporting" section*) 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 Management Data Warehouse (MDW), these 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 discrepancy due to error and/or other reporting issue.

Cadence of Performance Management Engagement

Performance management discussions between SCN Lead Entity leadership and OHIP contract managers will occur monthly during the first 12 months of the program and at least quarterly after the initial adoption period.

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 utilize the SCN Lead Entity Performance Improvement Plan template (to be provided by OHIP in further guidance) to provide uniform guidance and recommended workflows to the SCN Lead Entities 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 Monthly Horizon Report. Those metrics not marked with an asterisk will be calculated by OHIP and shared with SCN Lead Entities during regular performance management meetings.

Proposed metrics – final list to be communicated at a future date:

Screening:

- **Members screened (#, %)
- ** Members that decline consent (#, %)
- Screening results by HRSN type (#, %)
- 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 (#)
- Screening backlog volume (# of screenings outstanding over TBD business days, %)

Eligibility Assessment:

- **Members assessed (#, %)
- Members assessed by HRSN type (#, %)
- Members with positive screen who are successfully contacted within 5 business days (%)
- Eligibility Assessment criteria response type by SNOMED/ICD10 Code (as % of positive screens)
- Individuals eligible for HRSN services who decline services (#, % of Members)
- Individuals eligible for Enhanced HRSN Services by Enhanced Services Population (#, ID'ed by SCN)
- Members assessed by clinical criteria (#, ID'ed by SCN)
- Members assessed by duplicated service (#, ID'ed by SCN)

Referral:

- **Members referred (#, %)
- Members referred by HRSN type (#, %)
- Members referred within 7 business days (%)
- Referrals made that are accepted within 5 business days (%)
- Social Care Plans created (#)
- Referral backlog volume (# referrals outstanding over 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 with a positive HRSN screen who are provided information for HRSN Services within 7 business days (%)

Intervention / service delivery:

- **Members for which a service is initiated (#, %)
- **Closed Loop Referral rate (% of Referrals)
- **Members with Services Completed (#, %)
- Members for which a service is initiated, by HRSN type (#, %)
- Members with Services Completed, by HRSN type (#, %)
- Reauthorization of Enhanced HRSN Services (% of relevant Enhanced HRSN Services that are re-authorized)
- Accepted Referrals for which a service is initiated within TBD 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. If the SCN Lead Entity operates in multiple regions, separate reports must be submitted for each region. These reports must be submitted to the assigned contract manager for review by their assigned due date.

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.

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 Plan Performance Measures) and includes a series of questions related to Objectives	Quarterly
2. Monthly Performance Management Report *(Monthly Horizon Report)*	Report of HRSN Screenings, Eligibility Assessments, Referrals, and service delivery metrics, in addition to limited metrics for network and operational efficiency	Monthly
3. Governing Body Report	Report detailing governing body selection and, if needed, resubmission with any updates to the contract manager	One-time initial submission; resubmitted as needed
4. Network Composition Plan and Report	Report of network composition and quarterly reports to maintain and monitor network adequacy	One-time initial submission; Quarterly thereafter
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 funding	Quarterly
6. Budget Reassessment Report	Report of SCN re-assessment of current staffing and infrastructure needs and submission of Budget Modification, if applicable	Annually, and reassessment as needed

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 30 days after end for each quarter (e.g., January-March, April-June, July-September, October-December). Quarterly Performance Reports will be submitted using an OHIP-provided Word template. Additional instruction on the submission process will be shared in forthcoming guidance.

Table 6-2: Quarterly Performance Report required components

Report sections – subject to change per OHIP	
Category	**Component**
IT and Technology Infrastructure	• Narrative Progress Report • SCN IT Platform identification & functionality • Authorized user onboarding • 1115 SHIN-NY Interoperability Guidance[1] • Privacy, security, and compliance requirements
Network Administration, Capacity Building and Partnerships	• Narrative Progress Report • Network adequacy & technology assessment • Staff hiring & onboarding • MCO contracts • Staffing / Performance Reassessments
HRSN Screening and Service Delivery	• Narrative Progress Report • Social care claims submission process • Medicaid Members screened
Documentation and Performance Reporting Submission	• Summary update of main report submissions and adherence / guidance to standards

[1] SCN Lead Entities and their IT Platform partners can access more information at https://www.nyehealth.org/1115-waiver/.

ii. Monthly Performance Management Report *(Monthly Horizon Reports)*

(*Please see accompanying attachment SCN Instructions Manual for Monthly Horizon Reports to support with Monthly Horizon Report completion*)

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.

OHIP is likely to define specific targets related to select metrics and provide benchmarking across SCNs and regions to assess performance once baselines are established.

If the organization serving as the SCN Lead Entity is the SCN Lead Entity for multiple regions, Horizon Monthly Performance Reports must be broken down by assigned region and not submitted as aggregate.

Report Metrics and Details

SCN Lead Entities will calculate the required set of metrics in this report following detailed instructions provided to ensure standard submissions across SCN Lead Entities.

These instructions will contain Detailed Business Requirements (DBRs) for each metric – including 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 Monthly Horizon Report. A reporting template will also be provided to ensure consistent report format across all SCN Lead Entities.

Submission Details

The submission deadline for the first Monthly Horizon Report will be 15 days following the end of the first monthly performance period (e.g., 2/15/2025 for a first performance month of 1/1/2025-1/31/2025) and the fifteenth of every month thereafter. Monthly Horizon Reports will be submitted using an OHIP-provided Excel template. Additional instruction on the submission process will be shared in forthcoming guidance.

Table 6-3: Horizon Report Metrics

Metrics SCNs will submit on Monthly Horizon Report – subject to change per OHIP	
Category	**Metric**
HRSN Screening	• Members screened (#, %) • Members that decline consent (#, %)
Eligibility Assessment	• Members assessed (#, %)
Referral	• Members referred (#, %)
Intervention / service delivery	• Members for which a service is initiated (#, %) • Closed Loop Referral rate (% of Referrals) • Members with services completed (#, %)

Network capacity and access	• Size of Social Care Network • Composition of Social Care Network
Operational efficiency	• Payments to HRSN service providers within 30 business days (%)

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 Lead Entity or to modify 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.

NYC SCN Lead Entities may be awarded more than one borough in NYC (Bronx, Kings, Queens, New York, Richmond). The SCN Lead Entity would have one governing body representative for any awarded borough.

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. The SCN Lead Entity will be required to publicly share any updates to governing body reports and minutes on their website.

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 is prior to service start. Governing Body Reports will be submitted using an OHIP-provided Excel template. Additional instruction on the submission process will be shared in forthcoming guidance.

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 6-4: 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, healthcare (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 RFA scoring process, SCN Lead Entities submitted a Proposed Network Composition Plan to address gaps (RFA's Attachment J). An updated Network Composition Plan will be updated and submitted by 1/1/2025 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: Housing & Utilities, Food Security, Transportation, HRSN Screening & Navigation, and Other.

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 is 1/1/2025. The quarterly Network Composition Report submission deadline is 30 days after end for each quarter (e.g., January-March, April-June, July-September, October-December). Both the Network Composition Plan and Network Composition Reports quarterly will be submitted using an OHIP-provided Excel template. Additional instruction on the submission process will be shared in forthcoming guidance.

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 category • 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 • HRSN service provider interest in Infrastructure Capacity Building Funding • Zip codes served by HRSN service provider
Network adequacy	• Estimated monthly need for Enhanced HRSN Services by HRSN type • Estimated monthly capacity of the HRSN service provider to deliver services • Estimated gap between supply and demand of HRSN services • Plan to address capacity gaps for type of HRSN service

v. Infrastructure Cost Report

Report Description and Objectives

The SCN Lead Entity shall submit a comprehensive quarterly assessment of expenditures across relevant infrastructure categories, a detailed expense checklist by type of spend and a summary level Budget Statement and Report of Expenditures (BSROE). These cost-related reports will be used to monitor the spending of infrastructure funding and track expenditures to budgeted amounts. This report will further account for CBO spend of infrastructure 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 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 will also need to report additional details on allocation to organizations contracted within the Network, including the total amount expended for the reporting period and year-to-date. The SCN Lead Entity and contract manager will work in tandem to calculate capacity building funding, including the total of funds to be distributed to small organizations (e.g., CBOs with annual budget of less than $5 million)

Submission Details

Submission deadline of 30 days after end of each quarter (e.g., January-March, April-June, July-September, October-December). Infrastructure Cost Reports will be submitted using an OHIP-provided Excel template. Additional instruction on the submission process will be shared in forthcoming guidance.

Table 6-6: Infrastructure Cost Report required components.

Components – subject to change per OHIP	
BSROE Component	

Overall	• Personnel Services Detail
	  ○ Names, Salary, Budget & Expenditures by quarter, to date, and remaining balance, Fringe
	• Non-Personnel Services Detail
	  ○ Budget & Expenditures by quarter, to date, and remaining balance
	  ▪ Contractual Services, Travel, Equipment, Space / Property Expenses Rent / Own, Utility / Operating / 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

	• 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, and net changes. This includes when an SCN Lead Entity is submitting the Budget Modification Template or the New Year Budget Template. For Personnel Services, detailed positions, salaries, work weeks, FTE %, and months funded should be included. Additional details can be found in Table 6-7.

Submission Details

The submission deadline for this report will be 5/1/2025, and annually thereafter for the New Year Budget Report. Budget Reassessment Reports will be submitted using an OHIP-provided Excel template. Additional instruction on the submission process will be shared in forthcoming guidance.

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
	  ○ Contractual Services
	  ○ Current & Proposed Budget, Net Change
	  ▪ Contractual Services, Travel, Equipment, Space / Property Expenses Rent / Own, Utility / Operating / Other Expenses
	  ○ Justification, Calculation, and Reason for Change
	• Total & Proposed Contract Totals

c. MEMBER SATISFACTION

Member satisfaction is a key component of SCN performance and a priority of the SCN program. SCNs are expected to solicit Member feedback 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 and grievances, in an effort to improve Member satisfaction.

i. Member satisfaction survey

It is up to each SCN Lead Entity to determine the method for collecting Member satisfaction feedback from Members. Collection of feedback may be completed via a survey or other appropriate format that the SCN Lead Entity determines for their region. The format selected should enable the collection of data in a method that is sensitive, culturally appropriate, and accessible to a wide variety of Members.

OHIP expects that SCN Lead Entities will track Member satisfaction on a regular basis using survey data. As needed, OHIP may guide SCN Lead Entities to establish a Performance Improvement Plan to strengthen Member experience. OHIP may request to review Member satisfaction as part of regular performance discussions.

ii. Member grievances

Members can raise grievances with their SCN Lead Entity, either in communication with their Navigator and/or through a process determined by the SCN Lead Entity. SCN Lead Entities are expected to attempt to resolve Member grievances directly with the Member.

Members may also formally issue grievances with their MCO, which is expected to follow standard existing processes to achieve resolution. SCN Lead Entities are expected to ensure Members receive information on how to share grievances with both the SCN Lead Entity and MCO.

Additional guidance on Member grievances is forthcoming.

iii. Fair Hearing Rights

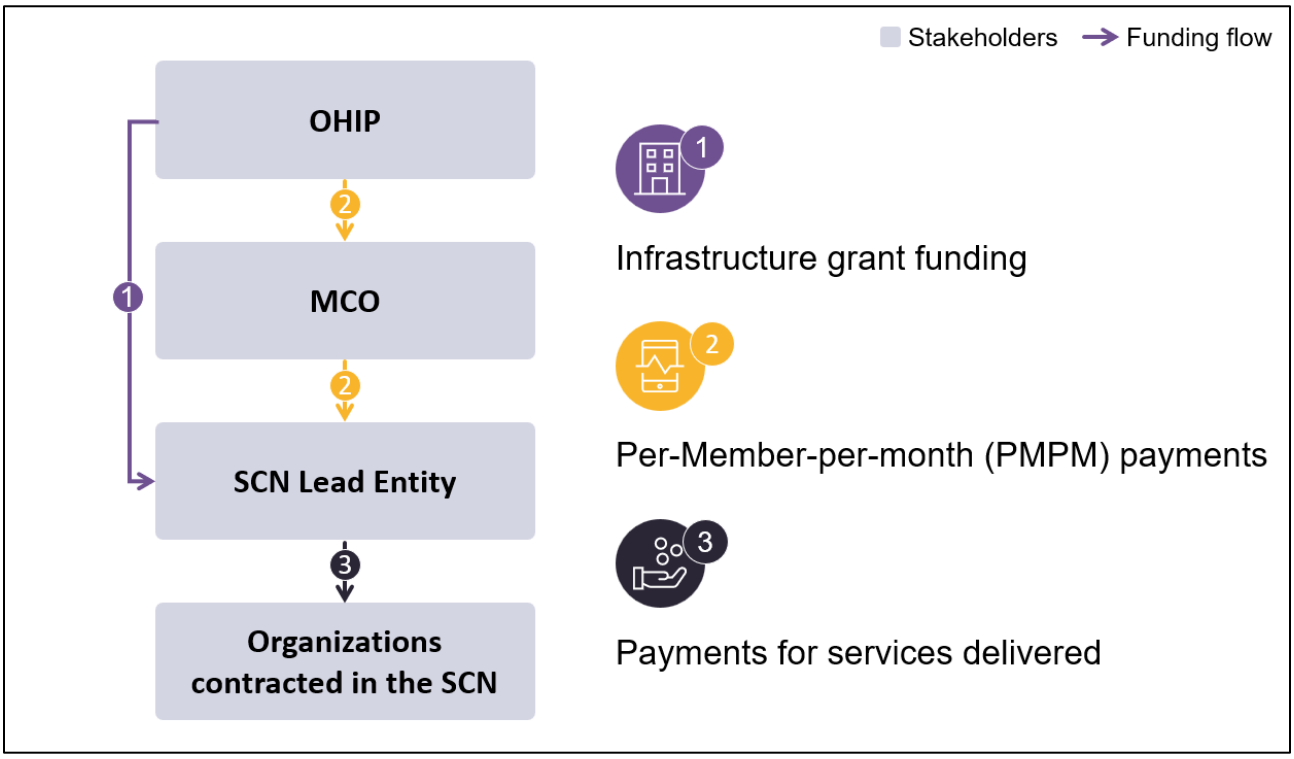
The SCN Lead Entity must have a procedure in place related to notifying Members/potential Members of their Fair Hearing rights, and participation in the Fair Hearing process. An individual may request a Fair Hearing for various issues, including issues related to eligibility and to the provision of HRSN Services and/or Enhanced HRSN Services. Member Fair Hearing Rights and Process will be shared as Attachment in the coming months.

7. PAYMENTS

SCNs will be funded under the 1115 Waiver until 3/31/2027. The SCNs will have three main funding sources throughout the three-year contract:

1. *Infrastructure grant funding:* Funding to SCNs for operational setup of the program. SCNs will use infrastructure funding to build necessary functionality of the Network.
2. *Per-Member-Per-Month (PMPM) payments:* Payments for Screening, Navigation, and Enhanced HRSN Services will flow from OHIP to the MCOs and from MCOs to SCN Lead Entities.
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 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 Managed Medicaid population.

After the 1115 Waiver period, a subsequent payment mechanism will be established. 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 GRANT 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 infrastructure grant funding for the operational setup of the program across the three-year RFA period.

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.

While OHIP's goal is to ensure that all SCNs achieve 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 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.

SCN Lead Entities will receive the majority of their infrastructure funding (the portion of funding tied to submitting required reports) prospectively, at the beginning of the quarter in which those funds will be spent. The portion of funding tied to completing key implementation milestones and achieving performance targets will be paid retrospectively after the milestones and targets are reached.

OHIP will pay SCN Lead Entities at the start of the 2nd month of each quarter.

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 healthcare provider engagement.

SCNs will be allowed 10% of infrastructure funding for administrative and operational costs, while at least 90% must be used for CBO capacity building and technical assistance. 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

Function	Type of cost	SCN activities covered by infrastructure funding
Data and IT	• People (salaried or vended) • Vendor • Software / hardware	• All set-up costs associated with procurement, implementation, and/or build out of SCN IT Platform
Network and partnerships / 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 and recruiting • Salaries + benefits for new positions
Contracting and fiscal management	• People (salaried or vended)	• Administration of contracts (MCO, HRSN service provider, and other regional ecosystem partner contracts)
Other administrative expenses	• People (salaried or vended)	• Hiring and recruiting • Salaries and benefits for new positions, training, and education
Physical space	• Office space • Office utilities	• Set-up of physical space

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 Year 1 (8/1/2024 – 3/31/2025)	Performance Year 2 (4/1/2025 – 3/31/2026)	Performance Year 3 (4/1/2026 – 3/31/2027)
Reporting	90% of infrastructure funding	85% of infrastructure funding	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	15% of infrastructure funding

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. This is to ensure that SCNs are building critical infrastructure and capacity quickly in order to accomplish program objectives. Specifically, beginning in Performance Year 2, SCNs must have cumulatively spent (before the prior quarter began) at least 70% of the funding received cumulatively before the prior quarter began to be eligible for new funding. For example, an SCN will be ineligible to receive payment in Q4 of Year 2 unless its total infrastructure spending from the beginning of the program through the end of Q2 of Year 2 is at least 70% of all the infrastructure payments it received through the end of Q2 of Year 2.

Reporting requirements

SCNs are required to submit 6 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. As funding tied to reporting is paid before the quarter ends, the payment amount will be deducted from the SCN's next quarterly payment if it fails to meet reporting requirements for the quarter.

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 required milestones are listed in *Table 7-3.* NYS will announce additional milestones due in Performance Year 2 and Performance Year 3 and infrastructure funding will be tied to those milestones in those years.

Table 7-3: Implementation milestones required for infrastructure funding

Implementation milestone	Deadline (subject to change)
Data and IT Platform identified	9/1/2024
Contracts in place with MCOs	10/1/2024
Social care claims process in place	11/1/2024
Competency with HL7 FHIR national standards	10/31/2024
SHIN-NY Participation Agreement Addendum	11/1/2024
Medicaid Critical Controls Attestation and System Overview Document	12/31/2024
1115 SHIN-NY Interoperability Established	1/1/2025
100% of proposed Network of HRSN service providers are onboarded onto the SCN IT platform	TBD
OHIP will announce additional milestones	TBD

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 requirements and 15% in Performance Year 3.

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 on the following metrics:

- Members screened (#, %)
- Members assessed (#, %)
- Members with positive screen 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.

b. PMPM PAYMENTS

(1/1/2025 – 3/31/2027)

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
- The MCO will then allocate a PMPM payment to each regional SCN Lead Entity once per month
- SCN Lead Entities will provide social care claims to all contracted MCOs for Enhanced HRSN Services provided to Members within the Network.
    - The service amount submitted on the social care claim will be based on a 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 and payments for services rendered. 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 reconciliations will begin six months after the close of the OHIP fiscal year (3/31), with the first reconciliation occurring on 9/30/2025
- *Process:*
    - OHIP will share reconciliation results with the MCO and the SCN
    - Within 30 days, the MCO and SCN must provide sign off approval, or provide feedback on, the reconciliation results with underlying documentation. In the event that the MCO or SCN contests the results, the MCO, SCN, and OHIP will commence a 30-day documentation review and investigative process to complete the reconciliation
    - OHIP will be responsible for determining 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 the encounter data indicates that aggregate PMPM payments net of the fees for services rendered is greater than the allowable PMPM (adjusted for permissible administrative allowance), 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 the encounter data indicates that aggregate PMPM payments net of the fees for services rendered is less than the allowable PMPM (adjusted for permissible administrative allowance), the excess payment will be provided to the SCN Lead Entities via the MCOs.

ii. Uses of funding

PMPM payments will primarily be used for the SCNs to reimburse contracted SCN organizations on a 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 re-screening due to a Major Life Event).

A maximum of 3% of PMPM payments can be used towards an MCO's administrative and operational costs each year. SCN Lead Entities may use a maximum of 3% of PMPM funds for ongoing administrative and operational costs incurred for service delivery (e.g., claims processing, performance management).

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

Social care claims for Enhanced HRSN Services will be uniform across all Medicaid MCOs and include the following:

- Screening services delivered by the Social Care Navigator

- Documentation of Screening / Navigation of service to connect Members to existing State, Federal or local services delivered by the SCN Lead Entity's contracted Social Care Network
- Enhanced HRSN Services delivered by SCN Lead Entity's contracted Network
- HRSN service provider information (e.g., Federal EIN, NPI)
- HCPCS code for the service, including any corresponding New York State-identified modifiers used
- HRSN service cost and units delivered
- Appropriate HRSN Coding considerations (e.g., ICD-10 Z-codes, SNOMED-CT Codes)

The SCN is expected to automate the process for submitting HRSN claims to MCOs. Social Care Claims for Enhanced HRSN Services must be sent to MCOs via Electronic Data Interchange (EDI) 837 file format. SCNs must receive and submit claims to MCOs via the SCN IT Platform within 90 days of the date of service.

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
- 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 Medicaid requirement

c. PAYMENT METHODOLOGY FOR SERVICES DELIVERED

(1/1/2025 – 3/31/2027)

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 a fee schedule approved by OHIP.

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 HRSN services with caps, OHIP will define SCN-level annual caps that take into account Member needs in each region (CTS Broker's Fee is only relevant for Region 4). Each SCN Lead Entity is responsible to manage spend for their region and ensure services do not exceed the defined cap. OHIP will provide additional guidance on specific caps prior to the start of service delivery.

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 a 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.
    - The SCN Lead Entity will provide fee schedule-based reimbursement payments to contracted HRSN service providers who render services for MMC Members no later than 30 days after service delivery. For home remediation services, reimbursement should be provided by the date specified in the contracted provider's invoice
    - Program-level funding caps for select 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 to manage these caps.

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 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 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

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 bill MCOs for services, activating the flow of funds to the SCN Lead Entity. The professional designation also allows the SCN Lead Entity to bill eMedNY for Medicaid FFS services (Screening and Navigation).

8. SCN CONTRACT REQUIREMENTS

SCN 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 entities within the Network

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 healthcare 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 1/1/2025.

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 Fee-For-Service (FFS) Members.

Only the awarded entity will become a designated SCN Lead Entity. The SCN Lead Entity will **NOT** be permitted to subcontract for Medicaid billing; the SCN Lead Entity's unique information such as MMIS# or other user identification / credentials is needed for Medicaid billing services.

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 1/1/2025
5	Every five years from contract execution, SCN Lead Entity is 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 healthcare 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 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 that 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

SCN Lead Entity shall comply with all directives from the State necessary to protect against actual or perceived conflicts of interest. If SCN Lead Entity engages in both service planning and service provision functions, it must obtain OHIP approval and maintain an OHIP-approved conflict-of-interest policy which shall include the provision of full disclosure of the dual relationship to Members, adequate separation of service planning and service provision functions within the organization (i.e., the employees performing service planning must be different from the employees performing service provision functions), a dispute resolution process, and periodic evaluation of its conflict-of-interest safeguards.

SCN Lead Entity as HRSN service provider

SCN Lead Entities that are designated a 501(c)(3) or 501(c)(4) may contribute to the HRSN services of Screening and Navigation. However, SCN Lead Entities will only be permitted by OHIP to also provide and be reimbursed for Enhanced HRSN Service delivery if they can maintain their OHIP-approved conflict-of-interest policy to ensure that Screening, Navigation, and Enhanced HRSN Service Delivery are performed in a manner that guards against conflicts of interest in accordance with all applicable requirements.

External Services

There may be circumstances where the SCN Lead Entities may offer services outside of the identified HRSN Waiver services. SCNs may continue to use outside sources to fund these services, but the 1115 Waiver funding and payments are to be used only for Enhanced HRSN Services approved by CMS and OHIP. SCN

Lead Entity must maintain a sufficient separation of Enhanced HRSN Services and outside services and the funds derived from and allocated to each.

Employee Conflict of Interest

SCN Lead Entities should disclose whether any members of its executive team, governing body, or any immediate family members thereof, have a direct or indirect interest in any contract that supplies administrative or care-related services or materials to the SCN Lead Entity and has an ongoing duty to disclose any other actual or perceived conflict of interest that should arise at any point during the term of the Agreement.

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 will provide 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. (*For more information on which Lines of Business are or are not eligible, see the MCO-SCN Agreement Template Attachment*)

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*)

v. MCO SCN IT Platform Training

The SCN Lead Entity must onboard, train, and support MCOs who elect to use the SCN's IT Platform if the MCO chooses to utilize the SCN IT Platform.

- SCN 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 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 in the MMCOR Service Utilization and Cost Reporting Guide (An example of the latest MMCOR Guidance can be found on the NYS Health Commerce System (HCS) website here). Users will need an HCS account to access this document.

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) and the MMCOR Category of Service Utilization and Cost Reporting Guide will provide 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.

Note that both the MMCOR Category of Service Utilization and Cost Reporting Guide and OSDS Encounter Standard Companion Guide are currently being updated to incorporate requirements that pertain to each HRSN service and will be made available at the weblinks above by service go-live.

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 and 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 necessary steps to amend the Model Contract to reflect the HRSN Screening and HRSN services including necessary workflows.

In the interim, OHIP will provide policy guidance for MCOs. (*For more information, refer to the section "SCN Contract Requirements with MCOs" or to the MCO-SCN Agreement Template*)

iv. Medicaid Member Protections

Medicaid Member protections include but are not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid Members' access to Medicaid covered services
ii. 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
iii. Medicaid Members who are offered or utilized an HRSN service retain all rights and protections afforded under 42 CFR 438
iv. 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
v. 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 (*For more information, see the SCN-provider agreement Attachment*). 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. Healthcare providers
iv. Medical Respite
v. Federally Qualified Health Centers (FQHCs)
vi. Health Homes (HHs)
vii. Article 26 HomeCare Social Service Providers
viii. Qualified Entities (QE)
ix. Subcontractors

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.

(*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 with the SCN
    - 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 provider should include the evaluation of the Medicaid Good Standing for any sister or parent agency associated to 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;
   - Allowability to bill for HRSN services completed at the same address as a licensed clinic site under Article 28, 31, or 32;
   - 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 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. Healthcare providers

SCN Lead Entities should coordinate closely with ecosystem partners such as healthcare providers, including health systems and independent practices. Healthcare providers that are contracted as part of the SCN and provide *only* Screening do not need to utilize the SCN IT Platform. However, for healthcare providers to conduct any other part of Member journey (e.g., Eligibility Assessments, Navigation, and / or HRSN service delivery), the healthcare 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 Medicaid 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;
- Understand that capacity funding provided to Medical Respites from their OHIP certification process is independent and separate from the SCN. Funds received under the Medical Respite Certification process will not preclude a Medical Respite from receiving Infrastructure Grant funding from the SCN

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
    - 1) Outreach another Medical Respite that may accept the Member
    - OR 2) 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 and written notification to the Member

vi. Federally Qualified Health Centers (FQHCs)

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, Enhanced HRSN Services.

FQHCs may be reimbursed for SCN services only if they have not been reimbursed by Medicaid fee-for-service, Medicaid Managed Care, or a third-party payer for those services. Additionally, FQHC's 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.

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 "Healthcare and Care Management Social Care Provider" member of the SCN governing body.

vii. Health Homes (HH)

SCNs are strongly encouraged to contract with all Health Homes in their region. HHs that are contracted to participate with the SCN may provide Screening and Enhanced HRSN Services. Health Homes that do not wish to join the SCN are encouraged to direct Members to the SCN for Screening and Navigation to services not offered through the Health Home.

Health Homes that are part of SCN

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 comprehensive assessment, HHs may:
    - Add additional questions to their existing screening process (e.g., education and employment)
    - Create a separate screening process within the SCN IT Platform
- HHs can start uploading screenings to receive payment by 1/1/2025

Navigation:

- HHs contracted into the SCN can conduct Navigation for both Members of the HH and Members outside of the HH, likely though Care Management Agencies (CMAs)
- For existing HH Members, HHs may include social care goals from the existing care plan in the SCN Social Care Plan to help 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
- Referral to and delivery of Enhanced HRSN Services

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)

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 have 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.

viii. Article 26 Homecare Social Service Providers

Article 26 Homecare Social Service Providers 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.

viii. Qualified Entities (QE)

SCNs must partner with QEs to send HRSN data to the NYeC/Statewide Health Information Network for New York (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, the MCO and also their regional SCN Lead Entity.

QE Participation Agreement (PA)

SCN Lead Entities will need to sign a QE Participation Agreement (PA) 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 Medicaid Roster 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) used and disclosed for purposes of the New York Health Equity Reform 1115 Waiver including transmittal to OHIP for program oversight.

ix. 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.

9. DATA GOVERNANCE, 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 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 Statewide Health Information Network for New York (SHIN-NY). SHIN-NY is a secure network designed for sharing electronic healthcare 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 healthcare collaboratively by leading, connecting, and integrating health information exchange (HIE) across the state and facilitating the sharing of information with healthcare 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 GOVERANCE 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 **Statewide Statewide Health Equity Regional Organization (***SHERO))

ii. Data ownership

An SCN Lead Entities 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 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 a Current State Security Risk Assessment, a Medicaid Critical Controls Attestation and System Overview, and through a Plan of Action and Milestones (POAM) report. By the end of the third year (**Year-3**) following the initiation of the contract with OHIP, the SCN Lead Entity must achieve HITRUST® Certification as a key component of its data stewardship and oversight program. More information on HITRUST® Certification is available from the HITRUST Alliance website. From the contract's commencement date onwards, OHIP will accept an appropriately scoped HITRUST® Certification with the NYS overlay.

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, NYS Privacy and Security Guidance for Qualified Entities (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 Protected Health Information (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).

SCN Lead Entities must meet federal and state laws, regulations, and security provisions outlined in the OHIP Moderate-Plus Security Controls Baseline based on the 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, OHIP has augmented these federal standards with New York State Policies and Standards. The Moderate-Plus Security Controls Baseline includes a System Overview document and the eighteen security control families as set forth in CMS ARS and NIST 800-53.

The importance of privacy and security cannot be overstated. Upon execution of the contract, the SCN Lead Entity will systematically strengthen its data privacy and security measures. The SCN Lead Entity's digital maturity will evolve over time. Achieving HITRUST Certification with the NYS overlay is the goal within three years, alongside 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.

SCNs must obtain affirmative Member consent before disclosing PHI or PII via SHIN-NY, with exceptions for emergencies and public health reporting. 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 for 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

- **New York State Division of Operations and Systems Security and Privacy Bureau**

The following Table 9-1 summarizes New York State's data and security requirements and deliverables from the SCN Lead Entity, organized by horizon year and due date. A more detailed summary follows in this section with hyperlinks to relevant resources.

ii. Summary of Privacy & Security requirements and deliverables

Table 9-1: Summary of SCN Data / Security requirements and their associated due dates

Data / Security Requirement / Deliverable	High Level Detail	Requirement Due Date
YEAR 1		
Meet with New York State's Security and Privacy Bureau on current state	Establish meeting with New York State's Security and Privacy Bureau on the current state of security readiness of SCN Lead Entity systems including any security certifications (HITRUST®, SOCII, etc.)	9/1/2024
Member Consent	The SCN shall integrate the Member Consent guidelines (*as detailed in the Consent section*) into the SCN IT Platform for a Member to complete before Screening is conducted	Must be in place **prior** to implementing Member Screening
HIPAA Compliance Assessment	The SCN shall ensure the IT Platform is HIPAA compliant and submit the HIPAA Compliance Assessment. If the IT Platform is not currently HIPAA compliant, the SCN Lead Entity shall outline its approach to ensuring the SCN IT Platform becomes HIPAA compliant	9/1/2024
SCN IT Platform Identified	SCN IT Platform identified	9/1/2024
SCN IT Platform User Authorization	Authorized SCN to onboard users to SCN IT Platform. Onboarding can continue as network grows.	9/1/2024
Competency with HL7 FHIR national standards	The SCN Lead Entity shall be capable of bi-directional data sharing using the HL7 FHIR national standards following implementation guide recognized by OHIP	Competency with FHIR data exchange deadline of **10/31/2024**
SHIN-NY Participation Agreement Addendum	The SCN Lead Entity shall ensure Participation Agreement Addendums are in place with the QE.	11/1/2024
Medicaid Critical Controls Attestation and	SCN Lead Entities must complete and submit to the Security and Privacy Bureau at doh.sm.Medicaid.Data.Exchange@health.ny.gov.	Must submit the Medicaid Critical

System Overview Document		Controls Attestation by 12/31/2024
SHIN-NY Interoperability Established	Required interoperability with SHIN-NY (*For more information on 1115 SHIN-NY Interoperability Guidance for SCN Lead Entities and their IT Platform partners, please visit the* NYeC Website 1115 Waiver support *website*)	SCN Lead Entities have until they start delivering services to connect their SCN IT Platforms with a QE.
All Privacy / security / compliance requirements	All privacy / security / compliance requirements met (Exception HITRUST® certification with the NYS overlay)	2/1/2025
YEAR 2		
Annual Privacy and Security Risk Assessment	All SCN Lead Entities not HITRUST® certified shall complete a Security Risk Assessment by an **independent entity** and submit to OHIP	By 8/1/2025 for those not yet HITRUST certified. Annual Privacy and Security Risk Assessment conducted and submitted to OHIP Conducted and submitted again by 8/1/2026 if not HITRUST certified by year 2.
Submit annual Medicaid Critical Controls Attestation and System Overview	Annual resubmission to the Security and Privacy Bureau	
YEAR 3		
HITRUST Certification	All SCN Lead Entities not HITRUST® certified will need to become certified by Year 3	1/1/2027

iii. Current State Security Risk Assessment

Following contract execution, the SCN Lead Entity will meet with New York State's Security and Privacy Bureau to assess the current state of security readiness of the SCN and its IT systems.

OHIP aims to guide SCN Lead Entities through a comprehensive process that will enable the SCNs to meet HITRUST® certification requirements. During the transition to HITRUST®, OHIP will require the SCN Lead Entity to complete and submit the Medicaid Critical Controls Attestation and System Overview Document. The SCN Lead Entity's transition to HITRUST® with the NYS overlay will be structured into phases over a three-year period.

Annual Privacy and Security Risk Assessment and Audit

Based on findings from assessments, attestations, audits, OHIP may require SCN Lead Entities to take action to correct any issues identified in a Plan of Action and Milestones (POAM) report. The SCN Lead Entity and OHIP will monitor progress against the POAM.

To further support SCN Lead Entities on meeting rigorous privacy and security standards, OHIP may provide resources to SCN Lead Entities needing additional support.

iv. Member Consent Management

SCNs are required to obtain affirmative Member consent before disclosing Protected Health Information (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*)

v. Authorization, Authentication, and Access

The SCN Lead Entity shall authorize which entities have authorization, authentication, and access to SCN data by **9/1/2024**.

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 establish SCN Data Collection, Use, and Sharing policies

SCNs must ensure that only approved entities and their staff that 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

vi. Member education, engagement, and access

Prior to screening, Members must be informed about the consent process, their rights to access their health information, and how to deny consent. SCNs must facilitate Member access to their PHI through various mechanisms, ensuring Members can direct their information to third parties, including Member applications.

vii. 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 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.

viii. Medicaid Critical Controls Attestation, System Overview, and Data Use Agreement

An SCN Lead Entity must complete the Medicaid Security review consisting of:

- Complete a Medicaid Critical Controls Attestation and system overview **by 12/31/2024**
- After acceptance of the Medicaid Critical Controls Attestation, the SCN Lead Entity will need to complete their HITRUST® Assessment/Certification. The scope of the audit will entail anything that stores, processes, accesses, or transmits PHI/PII. Once the HITRUST® with NYS overlay assessment is complete, the SCN Lead Entity will send a detailed copy of the assessment report to the Security and Privacy Bureau at doh.sm.Medicaid.Data.Exchange@health.ny.gov.

ix. 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 can be notified at **doh.sm.Medicaid.Data.Exchange@health.ny.gov** and **IncidentReport@health.ny.gov.**

x. Compliance and Certifications

HIPAA Compliance

HIPAA (Health Insurance Portability and Accountability Act) sets the standard for protecting health related and social care data, the non-medical factors that influence health outcomes. Any organization dealing with protected health information (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 9/1/2024** and prior to initiating operations.

In order to meet this requirement, the SCN Lead Entity will submit a HIPAA Compliance Assessment to the Security and Privacy Bureau at **doh.sm.Medicaid.Data.Exchange@health.ny.gov**.

State Regulations

There are two regulations that are currently in the process of being amended.

- 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 6/20/2024). For additional information see: DOS, 2024. State Register XLVI(28). Albany(NY): New York State Department of State.
- 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 6/26/2024). For additional information see: DOS, 2024. State Register XLVI(26). Albany(NY): New York State Department of State

HITRUST® Certification

HITRUST® Certification with the NYS overlay ensures that an organization meets the requirements of both ISO/IEC 2700-series and HIPAA, reducing the risk of loss of certification and contract.

ISO 27001 Certification

ISO 27001 Certification ensures that an organization has implemented an effective Information Security Management System (ISMS).

NIST 800-53 Certification

NIST 800-53 Certification ensures that an organization has implemented the necessary security controls to protect federal information systems.

SOC 2/SOC 3 Certification

SOC 2/SOC 3 Certification assesses the effectiveness of a vendor's systems in managing customer data.

xi. Sanctions

SCN Lead Entity shall be subject to sanctions from OHIP and SHIN-NY 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.

xii. Cybersecurity

The SCN Lead Entity must develop and maintain comprehensive cybersecurity policies and procedures, aligning with New York State's Health IT regulations and resources website. OHIP requires that the SCN Lead Entity has implemented robust security measures and controls to protect sensitive information and mitigate cybersecurity risks. To ensure the highest standards of cybersecurity and risk management, it is imperative that the SCN Lead Entity evolve from their current state to achieving HITRUST® with NYS overlay certification **within 36 months** of contracting with OHIP.

Health Information Trust Alliance (HITRUST®) Certification

New York State's objective is to guide SCN Lead Entities through a comprehensive process that will enable the SCNs to meet HITRUST® certification requirements. During the transition to HITRUST® certification, OHIP will require the SCN Lead Entity to submit an Annual Medicaid Critical Controls Attestation and System Overview. The SCN Lead Entity's transition will be structured into phases over a three-year period. (*For more information on HITRUST® certification see Navigating the Landscape of Trust in Information Assurance | HITRUST (hitrustalliance.net)*)

Year 1: Assessment and Planning

- Conduct a thorough assessment of the current cybersecurity posture
    - In year 1, SCN Lead Entities will have **until the end** of the year to complete and submit the Medicaid Critical Controls Attestation and System Overview
- Identify gaps and areas for improvement based on the NIST cybersecurity framework
- Develop a detailed action plan with specific milestones and deliverables

Year 2: Implementation and Monitoring

- Implement the necessary controls and processes as outlined in the action plan
- Conduct regular monitoring and internal audits to ensure compliance
    - SCN Lead Entities will need to do another audit by the end of Year 2 if not HITRUST® certified
- Provide ongoing training and support to staff to maintain high standards of cybersecurity practices

Year 3: Finalization and Certification

- Perform a final comprehensive audit to ensure all HITRUST® certification requirements are met
- Address any remaining gaps or issues identified during the audit
- Submit the necessary documentation and evidence for HITRUST® certification to OHIP

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® Fast Healthcare Interoperability Resources (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 10/31/2024**. 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://djq7jdt8kb490.cloudfront.net/1115/artifacts.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://djq7jdt8kb490.cloudfront.net/1115/artifacts.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 The Statewide Health Information Network for New York (SHIN-NY) Data Lake. If you 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 **10/1/2024.** 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://djq7jdt8kb490.cloudfront.net/1115/artifacts.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 both links are under development and will be updated throughout the next months as we learn more about what organizations need for this waiver. 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.

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. 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 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 here: https://www.nyehealth.org/1115-waiver/

LOINC (Logical Observation Identifiers Names and Codes) used for identifying health

Measurements, observations, and documents (e.g., Accountable health communities (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[2] (Systematized Nomenclature of Medicine – Clinical Terms)

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2 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 Licensees from the UTS Downloads site at https://uts.nlm.nih.gov.

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.

HCPCS (Healthcare Common Procedure Coding System)

HCPCS is a set of procedure codes based on CPT 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 (Fast Healthcare Interoperability Resources)

While not terminology per se, HL7 FHIR standards are crucial for the interoperability aspect of SDOH data. FHIR standards facilitate the exchange of healthcare information electronically, and 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 will share 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 9-2: Standardized terminologies and codes for SCN IT Platform

CARE DELIVERY APPROACH	SOCIAL CARE CODES	BILLING CODES
Screening	LOINC CD	**FFS:** Rate CD **Managed Care:** HCPS + State Defined Modifiers
Eligibility Assessment	SNOMED CT & ICD-10 (Z Codes)	N/A
Person-Centered Goals	SNOMED CT	N/A
Service Navigation / Care Management	SNOMED CT	**FFS:** Rate CD **Managed Care:** HCPS + State Defined Modifiers
HRSN Referral	SNOMED CT	N/A
HRSN Service Provision + Claims / Remittance	SNOMED CT	**Managed Care:** HCPS + State-Defined Modifiers, Rate CD (Medical Respite)

OHIP will use separate codes to identify and keep track of Fee-For-Service (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 at https://www.nyehealth.org/1115-waiver/. OHIP will publish a publicly available HRSN Fee Schedule (including billing codes) prior to service go-live.

Screening to Services Mapper: 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 Navigator should first locate the Member's positive need(s) from the AHC Screening Tool within this document. From the Member's identified positive response(s), the 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 Navigator/Member interactions may result in coding which deviates from the recommended mapping of codes.

(*Refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the live document: https://www.nyehealth.org/1115-waiver/ for a live copy of this document*)

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 (September 2024, March 2025) 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: https://www.nyehealth.org/1115-waiver/ for a live copy of this document.

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 9-3: AHC HRSN Screening Tool[3] LOINC codes[4, 5]

OHIP Accountable Health Communities (AHC) HRSN tool

SCREENING_PARENT_CODE	SCREENING_CODE_DESCRIPTION
NYSAHCHRSN	NYS Accountable Health Communities (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
		Water leaks	LA32001-2
		None of the above	LA9-3
	96779-4	**Yes**	LA33-6

3 The AHC HRSN Screening Tool https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf
4 AHC HRSN Screening tool https://loinc.org/96777-8
5 AHC HRSN supplemental questions https://loinc.org/97023-6

QUESTION	QUESTION_CODE	ANSWER_VALUE	ANSWER_CODE
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?		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
		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

QUESTION	QUESTION_CODE	ANSWER_VALUE	ANSWER_CODE
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.

For Direct Questioning by a Screener (Virtual, or In-Person)

Screening questions can be skipped by a Member, or a Navigator can make the decision not to ask these questions at their own discretion. However, if any of the safety questions (questions 9-12) are answered or asked, all must be answered or asked to produce an accurate safety score.

1. If a Member does decide to skip these questions, please keep FHIR observation value null and add DataAbsentReason of Asked but Declined.

2. If the screener decides not to ask a sensitive question. Keep observation value as null in FHIR and add DataAbsentReason of Not Asked with a text explanation as to why such as “Question was not appropriate to ask at time of screening."

Both solutions are specific to FHIR Observation Screening Response.

For Self-Administered Screenings (Website)

All questions are required to be answered (with the exception of interpersonal safety) or a Member will not be able to submit the screening.

iii. Eligibility Assessment ICD-1O / 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 human data entry by the Social Care Navigator. The Eligibility Assessment coding provided will trigger accurate referral information.

If a Member screens positive 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."

Table 9-4: Eligibility Assessment ICD-10 Z Codes and SNOMED-CT Codes

ICD10 Code	Description	SNOMEDCT	Description
Z59.00	**Homelessness unspecified**	**32911000**	**Homeless (finding)**
Z59.01	Sheltered Homelessness	611551000124102	Homelessness, living in a shared accommodation (finding)
Z59.01	Sheltered Homelessness	611131000124100	Sheltered homelessness (finding)
Z59.02	Unsheltered Homelessness	611141000124105	Unsheltered homelessness (finding)
Z59.02	Unsheltered Homelessness	611181000124104	Unsheltered homelessness, sleeping in safe environment (finding)
Z59.819	**Housing Instability, housed unspecified**	**1156191002**	**Housing Instability**
Z59.819	Housing instability, housed unspecified	1156193004	Housing instability due to frequent change in place of residence (finding)
Z59.819	Housing instability, housed unspecified	1156195006	Housing instability due to being behind on payments for place of residence (finding)
Z59.819	Housing instability, housed unspecified	1187272007	Housing instability due to housing cost burden (finding)
Z59.819	Housing instability, housed unspecified	1156196007	Housing instability due to threat of eviction (finding)
Z59.811	Housing instability, housed, with risk of homelessness	1156192009	Housing instability due to imminent risk of homelessness (finding)
Z59.812	Housing instability, housed, homelessness in past 12 months	1156194005	Housing instability following recent homelessness (finding)
Z59.19	Other inadequate housing	1162585007	Infestation of place of residence
Z59.19	Other inadequate housing	224255009	Mold growth in home
Z59.19	Other inadequate housing	1197631001	Lead in residence

ICD10 Code	Description	SNOMEDCT	Description
Z59.11	Inadequate housing environmental temperature	105535008	Lack of heat in house
Z59.19	Other inadequate housing	1197634009	Inadequate food preparation equipment in residence
Z59.19	Other inadequate housing	1197640002	Inadequate smoke detection equipment in residence
Z59.19	Other inadequate housing	105531004	Housing unsatisfactory (finding)
N/A		N/A	
Z59.12	**Inadequate housing utilities**	**105531004**	**Housing unsatisfactory (finding)**
Z59.12	Inadequate housing utilities	105536009	Living in housing without electricity (finding)
Z59.12	Inadequate housing utilities	5491000175103	Lack of running water in house (finding)
Z59.12	Inadequate housing utilities	671391000124106	Unable to obtain electricity in residence due to limited financial resources (finding)
Z59.12	Inadequate housing utilities	671371000124105	Unable to heat residence due to limited financial resources (finding)
Z59.12	Inadequate housing utilities	671401000124108	Unable to cool residence due to limited financial resources (finding)
All codes may be supplemented with…			
Z59.87	Material hardship due to limited financial resources, not elsewhere classified		
Z59.41	**Food insecurity**	**733423003**	**Food insecurity (finding)**
Z59.82	**Transportation insecurity**	**551691000000000**	**Transportation insecurity (finding)**
Z59.82	Transportation insecurity	551761000000000	Transportation insecurity due to unaffordable transportation (finding)
Z59.82	Transportation insecurity	551741000124108	Transportation insecurity due to no access to vehicle (finding)
Z59.82	Transportation insecurity	713458007	Lack of access to transportation (finding)
Z59.82	Transportation insecurity	551721000124101	Transportation insecurity due to no driver's license (finding)
Z59.82	Transportation insecurity	551711000124109	Transportation insecurity due to excessive travel time to destination (finding)
Z59.82	Transportation insecurity	160696009	Transport distance too great (finding)
Z59.82	Transportation insecurity	611151000124107	Transportation insecurity due to route not serviced by public transportation (finding)
Z59.82	Transportation insecurity	160696009	Transport distance too great (finding)
Z59.82	Transportation insecurity	551701000000000	Transportation insecurity due to unsafe transportation environment (finding)
Z59.82	Transportation insecurity	611161000124109	Transportation insecurity limiting access to food (finding)
Z59.82	Transportation insecurity	551731000124103	Inability to access healthcare due to transportation insecurity (finding)
Z59.82	Transportation insecurity	551751000124105	Inability to access community resources due to transportation insecurity (finding)

iv. 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 HSRNs. Goals may also be directly referenced in a Referral by the Social Care Navigator (i.e., FHIR ServiceRequest bundle with Goal, etc.). The following table outlines the SNOMED Code and the description to enable.

Table 9-5: Person-Centered Goal Setting SNOMED-CT Codes

SNOMED-CT Code	Code Description
1078229009	Food security (finding)
671311000124101	Feels food intake quantity is adequate for meals and snacks (finding)
1162437009	Coordination of resources to address housing instability (procedure)
1204360006	Adequate food preparation equipment in residence (finding)
1204361005	Adequate cooling in residence (finding)
1204362003	Adequate heating in residence (finding)
1208722008	No known infestation in residence (situation)
1208723003	No known mold in residence (situation)
1268689003	Able to afford utilities in residence (finding)
161036002	Housing adequate (finding)
185960001	Housing problem solved (finding)
611171000124102	Residence meets functional needs (finding)
611181000124104	Unsheltered homelessness, sleeping in safe environment (finding)
611211000124100	Housing security (finding)
611221000124108	Stably housed (finding)
1268687001	Feels transportation time to destination is acceptable (finding)
611271000124109	Transportation security (finding)
611461000124101	Able to afford transportation related expense (finding)
611511000124103	Has transportation to access community resources (finding)

v. 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.

For all codes listed as "Code ETA" in the tables below, SCNs will be provided a local code to use by the week of 10/5/2024.

Navigation population members are navigated to existing services to meet their HRSNs.

Table 9-6: Navigation to HRSN related services: SNOMED-CT Codes

SNOMED-CT Code	Code Description / Proposed Language
464101000124108	Referral to Supplemental Nutrition Assistance Program (procedure) - SNAP
621331000124108	Referral to Temporary Assistance for Needy Families program (procedure) - TANF
464111000124106	Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure) - WIC
621361000124104	Referral to Low Income Home Energy Assistance program (procedure)
481051000124108	Referral to healthcare utilization management service
183583007	Referral to mental health counseling service (procedure)
396150002	Referral for substance abuse
4266003	Referral to drug addiction rehabilitation service (procedure)
390866009	Referral to mental health team
453621000124100	Referral to primary care provider
449221000124102	Referral to different healthcare provider
Code ETA 3/1/25[6]	*Referral to health plan's care management program*
1162436000	Referral to legal aid (procedure)
1230365006	Referral to basic skills training program (procedure)
663061000124105	Referral to Supported Employment Program (procedure)
1230339007	Referral to job center (procedure)
1254708009	Referral to workforce transition program (procedure)
18781004	Referral to vocational rehabilitation service (procedure)
662941000000000	Referral to workforce training program (procedure)
662891000000000	Referral to Fair Employment Practice Agency (procedure)
621381000000000	Referral to general educational development program (procedure)
662901000000000	Referral to high school completion program for attainment of diploma (procedure)
663071000000000	Referral to Supported Education Program (procedure)
663141000000000	Referral to vocational education program (procedure)
663291000000000	Referral to early-college high school program (procedure)
415271004	Referral to education service
1230284006	Referral to tutoring program (procedure)
1230365006	Referral to basic skills training program (procedure)
1230285007	Referral to adult learning center (procedure)

6 NYS is awaiting code assignment

SNOMED-CT Code	Code Description / Proposed Language
662931000000000	Referral to intimate partner violence service (procedure)
663011000000000	Referral to victim advocate program (procedure)
621341000000000	Referral to National Domestic Violence Hotline (procedure)
472161000124106	Referral to housing support program (procedure)

Table 9-7: Referral to Enhanced HRSN Services: Care Management SNOMED-CT Codes

SNOMED-CT Code	Code Description
11541000175105	Referral to care management service
464011000124107	Referral to care manager (procedure)
481051000124108	Referral to healthcare utilization management service
183583007	Referral to mental health counseling service (procedure)
464101000124108	Referral to Supplemental Nutrition Assistance Program (procedure) - SNAP
621331000124108	Referral to Temporary Assistance for Needy Families program (procedure) - TANF
464111000124106	Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure) - WIC
621361000124104	Referral to Low Income Home Energy Assistance program (procedure)
472161000124106	Referral to housing support program (procedure)
396150002	Referral for substance abuse
4266003	Referral to drug addiction rehabilitation service (procedure)
390866009	Referral to mental health team
453621000124100	Referral to primary care provider
449221000124102	Referral to different healthcare provider
Code ETA: 3/1/25	*Referral to health plan's care management program*
1162436000	Referral to legal aid (procedure)
1230365006	Referral to basic skills training program (procedure)
663061000124105	Referral to Supported Employment Program (procedure)
1230339007	Referral to job center (procedure)
1254708009	Referral to workforce transition program (procedure)
18781004	Referral to vocational rehabilitation service (procedure)
662941000000000	Referral to workforce training program (procedure)
662891000000000	Referral to Fair Employment Practice Agency (procedure)
621381000000000	Referral to general educational development program (procedure)
662901000000000	Referral to high school completion program for attainment of diploma (procedure)
663071000000000	Referral to Supported Education Program (procedure)
663141000000000	Referral to vocational education program (procedure)
663291000000000	Referral to early-college high school program (procedure)
415271004	Referral to education service

SNOMED-CT Code	Code Description
1230284006	Referral to tutoring program (procedure)
1230365006	Referral to basic skills training program (procedure)
1230285007	Referral to adult learning center (procedure)
621411000124107	Referral to child care financial assistance program (procedure)|
621341000000000	Referral to National Domestic Violence Hotline (procedure)
472151000124109	Referral to medical legal partnership program (procedure)

Table 9-8: Referral to Enhanced HRSN services: Care Management SNOMED-CT Codes

SNOMED-CT Code	Code Description
11541000175105	Referral to care management service
464011000124107	Referral to care manager (procedure)
481051000124108	Referral to healthcare utilization management service
183583007	Referral to mental health counseling service (procedure)
464101000124108	Referral to Supplemental Nutrition Assistance Program (procedure) - SNAP
621331000124108	Referral to Temporary Assistance for Needy Families program (procedure) - TANF
464111000124106	Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure) - WIC
621361000124104	Referral to Low Income Home Energy Assistance program (procedure)
472161000124106	Referral to housing support program (procedure)
396150002	Referral for substance abuse
4266003	Referral to drug addiction rehabilitation service (procedure)
390866009	Referral to mental health team
453621000124100	Referral to primary care provider
449221000124102	Referral to different healthcare provider
Code ETA: 3/1/25	*Referral to health plan's care management program*
1162436000	Referral to legal aid (procedure)
1230365006	Referral to basic skills training program (procedure)
663061000124105	Referral to Supported Employment Program (procedure)
1230339007	Referral to job center (procedure)
1254708009	Referral to workforce transition program (procedure)
18781004	Referral to vocational rehabilitation service (procedure)
662941000000000	Referral to workforce training program (procedure)
662891000000000	Referral to Fair Employment Practice Agency (procedure)
621381000000000	Referral to general educational development program (procedure)
662901000000000	Referral to high school completion program for attainment of diploma (procedure)
663071000000000	Referral to Supported Education Program (procedure)
663141000000000	Referral to vocational education program (procedure)

SNOMED-CT Code	Code Description
663291000000000	Referral to early-college high school program (procedure)
415271004	Referral to education service
1230284006	Referral to tutoring program (procedure)
1230365006	Referral to basic skills training program (procedure)
1230285007	Referral to adult learning center (procedure)
621411000124107	Referral to child care financial assistance program (procedure)|
621341000000000	Referral to National Domestic Violence Hotline (procedure)
472151000124109	Referral to medical legal partnership program (procedure)

vi. 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.

Table 9-9: Intervention Codes for provision of HRSN services: SNOMED-CT

HRSN Area	SNOMED-CT Code	Code Description / Proposed Language
Transportation	551191000124100	Assistance with application for taxi voucher program (procedure)
Transportation	551241000124100	Assistance with application for fuel voucher program (procedure)
Transportation	551271000124108	Assistance with application for vehicle donation program (procedure)
Transportation	551291000124109	Assistance with application for transportation network company program (procedure)
Transportation	551421000124106	Assistance with application for bicycle share program (procedure)
Transportation	610961000124100	Assistance with application for volunteer driver program (procedure)
Transportation	610971000124107	Assistance with application for rideshare program (procedure)
Transportation	610981000124105	Assistance with application for public transportation voucher program (procedure)
Transportation	610991000124108	Assistance with application for paratransit program (procedure)
Transportation	611001000124109	Assistance with application for microtransit program (procedure)
Transportation	611021000124104	Assistance with application for automobile share program (procedure)
Transportation	651011000124100	Assistance with application for vehicle repair program (procedure)
Transportation	228615008	Provision of transportation related to care management
Transportation	228615008	Provision of transportation related to HRSN Service
Nutrition	464101000124108	Referral to Supplemental Nutrition Assistance Program (procedure) - SNAP
Nutrition	621331000124108	Referral to Temporary Assistance for Needy Families program (procedure) - TANF
Nutrition	464111000124106	Referral to Special Supplemental Nutrition Program for Women, Infants and Children (procedure) - WIC
Nutrition	467681000124101	Assistance with application for Summer Food Service Program (procedure)

HRSN Area	SNOMED-CT Code	Code Description / Proposed Language
Nutrition	467691000124103	Assistance with application for Special Supplemental Nutrition Program for Women, Infants and Children (procedure)
Nutrition	467721000124108	Assistance with application for Medically Tailored Meals Program (procedure)
Nutrition	467731000124106	Assistance with application for Home-Delivered Meals Program (procedure)
Nutrition	467761000124102	Assistance with application for food prescription program (procedure)
Nutrition	467771000124109	Assistance with application for food pantry program (procedure)
Nutrition	467781000124107	Assistance with application for Child and Adult Care Food Program (procedure)
Nutrition	467801000124106	Assistance with application for Community Meal Program (procedure)
Nutrition	467711000124100	Assistance with application for Senior Farmers' Market Nutrition Program (procedure)
Nutrition	467811000124109	Assistance with application for Farmers' Market Nutrition Program for Women, Infants and Children (procedure)
Nutrition	470241000124102	Assistance with application for national school lunch program (procedure)
Nutrition	662151000124104	Assistance with application for State Funded Food Assistance Program (procedure)
Nutrition	410293007	Food education, guidance, and counseling (procedure)
Nutrition	464431000124105	Provision of medically tailored meals (procedure)
Nutrition	464721000124102	Provision of food prescription (procedure)
Nutrition	464411000124104	Provision of food voucher (procedure)
Nutrition	710925007	Provision of food (procedure)
Employment / Education	611011000124107	Assistance with application for Non-Emergency Medical Transportation program (procedure)
Employment / Education	1230365006	Referral to basic skills training program (procedure)
Employment / Education	663061000124105	Referral to Supported Employment Program (procedure)
Employment / Education	1230339007	Referral to job center (procedure)
Employment / Education	1254708009	Referral to workforce transition program (procedure)
Employment / Education	18781004	Referral to vocational rehabilitation service (procedure)
Employment / Education	662941000000000	Referral to workforce training program (procedure)

HRSN Area	SNOMED-CT Code	Code Description / Proposed Language
Employment / Education	662891000000000	Referral to Fair Employment Practice Agency (procedure)
Employment / Education	621381000000000	Referral to general educational development program (procedure)
Employment / Education	662901000000000	Referral to high school completion program for attainment of diploma (procedure)
Employment / Education	663071000000000	Referral to Supported Education Program (procedure)
Employment / Education	663141000000000	Referral to vocational education program (procedure)
Employment / Education	663291000000000	Referral to early-college high school program (procedure)
Employment / Education	415271004	Referral to education service
Employment / Education	1230284006	Referral to tutoring program (procedure)
Employment / Education	1230365006	Referral to basic skills training program (procedure)
Employment / Education	1230285007	Referral to adult learning center (procedure)
Housing	621361000124104	Referral to Low Income Home Energy Assistance program (procedure)
Housing	472161000124106	Referral to housing support program (procedure)
Housing	470471000124109	Assistance with application for rental assistance program (procedure)
Housing	470481000124107	Assistance with application for subsidized housing program (procedure)
Housing	661851000124101	Assistance with application to utility assistance program (procedure)
Housing	480861000124108	Assistance with application to Homelessness Prevention program (procedure)
Housing	480921000124106	Assistance with application to Emergency Shelter program (procedure)
Housing	710925007	Provision of food (procedure)
Housing	472131000124102	Provision of rental assistance voucher (procedure)
Housing	472081000124102	Education about rental assistance program (procedure)
Housing	228619002	Provision of ramp (procedure)
Housing	228618005	Provision of handrail (procedure)
Housing	228618005	Provision of handrail (procedure)
Housing	713794007	House dust mite barrier pillowcase (physical object) |
Housing	713796009	House dust mite barrier bed mattress cover (physical object)

HRSN Area	SNOMED-CT Code	Code Description / Proposed Language
Care Management	11541000175105	Referral to care management service
Care Management	464011000124107	Referral to care manager (procedure)
Care Management	1254703000	Assistance with application for financial counseling program (procedure)
Care Management	662051000124103	Assistance with application for Adult Protective Services (procedure)
Care Management	481051000124108	Referral to healthcare utilization management service
Care Management	183583007	Referral to mental health counseling service (procedure)
Care Management	396150002	Referral for substance abuse
Care Management	4266003	Referral to drug addiction rehabilitation service (procedure)
Care Management	390866009	Referral to mental health team
Care Management	453621000124100	Referral to primary care provider
Care Management	449221000124102	Referral to different healthcare provider
Care Management	1162436000	Referral to legal aid (procedure)
Care Management	661911000124109	Assistance with application for childcare financial assistance program (procedure)|
Care Management	621411000124107	Referral to childcare financial assistance program (procedure)|
Care Management	662311000124102	Evaluation of eligibility for childcare financial assistance program (procedure)|
Care Management	662931000000000	Referral to intimate partner violence service (procedure)
Care Management	663011000000000	Referral to victim advocate program (procedure)
Care Management	621341000000000	Referral to National Domestic Violence Hotline (procedure)
Care Management	1148446004	Education about legal aid (procedure)
Care Management	1162436000	Referral to legal aid (procedure)
Care Management	472331000124100	Education about medical legal partnership program (procedure)
Care Management	472151000124109	Referral to medical legal partnership program (procedure)
Care Management	698605001	Education about asthma self-management (procedure)

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.

Table 9-10: Proposed Intervention Codes for HRSN services: SNOMED-CT

To ensure that programmatic needs for Referral specificity is 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 to until official coding is released (see anticipated publication dates below).

Anticipated Publication Date	HRSN	Code Description / Proposed Language
9/1/2024	Nutrition	Provision of refrigerator
9/1/2024	Nutrition	Provision of kitchenware
9/1/2024	Nutrition	Provision of microwave
9/1/2024	Nutrition	Provision of refrigerator
9/1/2024	Housing	Provision of payment for housing security deposit
9/1/2024	Housing	Provision of payment for one month rent
9/1/2024	Housing	Provision of payment for real estate broker fee
9/1/2024	Housing	Provision of payment for housing utility
9/1/2024	Housing	Provision of payment for housing moving costs
9/1/2024	Housing	Provision of payment for housing pest control fee
9/1/2024	Housing	Provision of payment for housing inspection to support housing transition
9/1/2024	Housing	Provision of essential household goods to support housing transition
9/1/2024	Housing	Payment of utility activation expenses
9/1/2024	Housing	Assistance with application for housing
9/1/2024	Housing	Assistance with tenant screening process
9/1/2024	Housing	Assistance with negotiating housing lease
9/1/2024	Housing	Assistance with tenant interview process
9/1/2024	Housing	Education about tenant rights
9/1/2024	Housing	Provision of payment for ventilation system repair or improvement
9/1/2024	Housing	Provision of payment for mold and pest remediation
9/1/2024	Housing	Provision of air conditioner
9/1/2024	Housing	Provision of humidifier
9/1/2024	Housing	Provision of home air filtration device
9/1/2024	Housing	Provision of payment for housing mold remediation fee (procedure)
9/1/2024	Housing	Provision of payment for housing pest control fee
9/1/2024	Care Management	Provision of payment for benefit program application fee
9/1/2024	Care Management	Assistance with search for childcare
3/1/2025	Housing	Assistance with search for housing
3/1/2025	Housing	Payment of utility arrears
3/1/2025	Housing	Counseling about management of finances
3/1/2025	Housing	Assistance with housing lease renewals
3/1/2025	Housing	"Pre-procedure medical respite care for homelessness"
3/1/2025	Housing	Post-hospitalization medical respite care for homelessness

Anticipated Publication Date	HRSN	Code Description / Proposed Language
3/1/2025	Employment / Education	Assistance with school enrollment
3/1/2025	Employment / Education	Assistance with employment application
3/1/2025	Care Management	Referral to health plan's care management program
3/1/2025	Care Management	Assistance with search for childcare
To be scheduled	Housing	Payment of utility costs (up to 6 mo.)
To be scheduled	Housing	Provision of dehumidifier
To be scheduled	Housing	Provision of space heater
To be scheduled	Housing	Provision of humidity meter – *pending Gravity confirmation*
To be scheduled	Housing	Provision of vacuum – *pending Gravity confirmation*
To be scheduled	Housing	Provision of filters – *pending Gravity confirmation*
To be scheduled	Housing	Provision of Indoor Air Quality Equipment and Services?

vii. 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.

Payments made by MCOs to HRSN service providers by way of SCNs based on DOH-defined HRSN Service Fee Schedule, fee schedule-based reimbursement for Enhanced HRSN services rendered by HRSN service providers.

Table 9-11: Billing and Payment: HCPCS and Modifiers

Service Name	HCPCS Code	State-defined Modifiers	Rate Code
Asthma Remediation – Air conditioner	S5165	U6, U9	N/A
Asthma Remediation – Air duct maintenance	S5165	UA, U4	N/A
Asthma Remediation – Basement water proofing	S5165	UB, U4	N/A
Asthma Remediation – Cleaning and installation of gutter screens and downspouts	S5165	UB, U2	N/A
Asthma Remediation – Carpet removal	S5165	UB, U8	N/A
Asthma Remediation – Carpet steam cleaning	S5165	UB, U7	N/A
Asthma Remediation – Dirt floor vapor barrier	S5165	UB, U3	N/A
Asthma Remediation – Dryer vent cleaning	S5165	U9, U4	N/A
Asthma Remediation – Exhaust fans	S5165	U8, U4	N/A
Asthma Remediation – Forced Air furnace and additional filters	S5165	U7, U4	N/A
Asthma Remediation – Integrated Pest Management (IPM)	S5165	U8, U6	N/A
Asthma Remediation – Repairing water damage	S5165	UB, U9	N/A
Asthma Remediation – Self Management Education - (In-person Visit)	S9441	U6, U5	N/A
Asthma Remediation - Self Management Education - (Telehealth / Teleconference)	S9441	U6, U6	N/A
Asthma Remediation - Supportive Products (Asthma Friendly Cleaning Supplies)	T2025	U6, U8	N/A
Asthma Remediation - Supportive Products (Indoor Allergen Reduction)	T2025	U9, U6	N/A
Clinically Appropriate Meals	S5170	U6, U4	N/A
Community Transitional Supports – Security Deposit	T2025	UB, U5	N/A
Community Transitional Supports – Broker's Fees (Region 4 Only)	T2025	U4, U2	N/A
Community Transitional Supports – First Month's Rent	T2025	U4, U1	N/A
Community Transitional Supports – Moving and Relocation Expenses	T2025	U4, U4	N/A
Community Transitional Supports – Pantry Stocking	T2025	UC, U1	N/A
Community Transitional Supports – Utility Activation Fees	T2025	U4, U3	N/A

Service Name	HCPCS Code	State-defined Modifiers	Rate Code
Community Transitional Supports – Household Goods and Furniture	T2025	UC, U2	N/A
Community Transitional Supports – Pest Eradication and Inspection Fees	T2025	U4, U5	N/A
Cooking Supplies – Kitchenware	T2025	UA. U6	N/A
Cooking Supplies – Microwave	T2025	U6, UA	N/A
Cooking Supplies – Refrigerator	T2025	U6, UB	N/A
Home Accessibility and Safety Modifications – Air Conditioner	S5165	U8, UC	N/A
Home Accessibility and Safety Modifications – Air Filtration Devices	S5165	UA, UC	N/A
Home Accessibility and Safety Modifications – De-humidifier	S5165	U4, U7	N/A
Home Accessibility and Safety Modifications – Heater	S5165	U5, U4	N/A
Home Accessibility and Safety Modifications – Humidifier	S5165	U9, UC	N/A
Home Accessibility Modifications – Accessibility Ramps	S5165	U3, UC	N/A
Home Accessibility Modifications – Bathroom Facilities	S5165	U1, U4	N/A
Home Accessibility Modifications – Doors and Cabinet Handles	S5165	U4, UB	N/A
Home Accessibility Modifications – Electric Door Opener	S5165	U4, U9	N/A
Home Accessibility Modifications – Grab Bars	S5165	U5, UC	N/A
Home Accessibility Modifications – Handrails	S5165	U4, UC	N/A
Home Accessibility Modifications – Kitchen Cabinet or Sinks	S5165	U2, U4	N/A
Home Accessibility Modifications – Non-skid Surfaces	S5165	U3, U4	N/A
Home Accessibility Modifications – Pathways	S5165	U4, U8	N/A
Home Accessibility Modifications – Widening Of Doorway	S5165	U4, UA	N/A
Home Modification and Remediation Services-Mold and Pest Remediation	S5165	U7, UC	N/A
Home Modification and Remediation Services-Repairing and Improving ventilation systems	S5165	U6, UC	N/A
Housing Transition and Navigation Services	H0043	UA, U5	N/A
Home Remediation: Equipment Provision	S5165	U6, U1	N/A
HRSN Care Management – Care Management Level 2 Only	T2022	U5, U3	N/A
HRSN Care Management – Clinical Care Management Level 2 Only	T2023	U5, U9	N/A
HRSN Care Management – Crisis Services Level 2 Only	T2023	U5, UB	N/A
HRSN Care Management – Application Assistance Level 2 Only	T2023	U5, U7	N/A
HRSN Care Management – Application Fees Level 2 Only	T2023	U5, U8	N/A
HRSN Care Management – Behavioral Health Services Level 2 Only	T2023	U5, UA	N/A
HRSN Care Management – Employment Level 2 Only	T2023	U3, U5	N/A
HRSN Care Management – Existing Benefit Programs Level 2 Only	T2023	U5, U5	N/A
HRSN Care Management – Healthcare Providers Level 2 Only	T2023	U3, UA	N/A
HRSN Care Management – Legal Assistance Level 2 Only	T2023	U2, U5	N/A
HRSN Care Management – MCOs Level 2 Only	T2023	U1, U5	N/A

Service Name	HCPCS Code	State-defined Modifiers	Rate Code
HRSN Care Management – Childcare Level 2 Only	T2023	U7, U5	N/A
HRSN Care Management – Education Level 2 Only	T2023	U3, U8	N/A
HRSN Care Management – Follow Up Level 2 Only	T2023	U9, U5	N/A
HRSN Care Management – Interpersonal Violence Resources Level 2 Only	T2023	U8, U5	N/A
HRSN Private Transportation – Care Management	T2025	U4, U6	N/A
HRSN Private Transportation – HRSN Services Only	T2025	U7, U6	N/A
HRSN Public Transportation – Care Management	T2025	U3, U6	N/A
HRSN Public Transportation – HRSN Services Only	T2025	U5, U6	N/A
Medical Respite (Recuperative Care) - Pre and Post Hospitalization	TBD	N/A	7980
Medically Tailored Meals (MTM)	S5170	U6, U7	N/A
Medically Tailored or Nutritionally Appropriate Food Prescriptions – Boxes	T2025	UB, U6	N/A
Medically Tailored or Nutritionally Appropriate Food Prescriptions – Voucher	T2025	U5, U1	N/A
Nutritional Counseling and Education-Counseling and Education	97802	U6, U2	N/A
Nutritional Counseling and Education-Counseling and Education	97803	U6, U3	N/A
Fresh Produce and Nonperishable Groceries (Pantry Stocking)	T2025	U2, U6	N/A
Pre-tenancy services – Housing Search, Availability and Information	T2025	UC, UA	N/A
Pre-tenancy services – Navigating and Completing Housing Application	T2040	UC, U6	N/A
Pre-tenancy services – Negotiating Lease Agreements	T2040	UC, U8	N/A
Pre-tenancy services – Tenant Interviews	T2025	UC, U9	N/A
Pre-tenancy services – Tenant Screening Assistance	T2025	UC, U7	N/A
Rent and Temporary Housing- Rent cost for up to 6 months	H0044	UC, U5	N/A
Rent and Temporary Housing-Utility cost for up to 6 months	H0044	UB, UC	N/A
Re-screening – All Medicaid Member Screening	G0136	UB, UA	N/A
Screening – All Medicaid Member Screening	G0136	UA, UB	N/A
Social Care Navigation – Level 1 Only	T2022	U5, U2	N/A
Tenancy Sustaining services – Rights, Education, Eviction Prevention, Dispute Resolution, Risk Intervention	T2040	UC, UB	N/A
Tenancy Sustaining services – Financial Education, Literacy and Resources	T2040	U1, UC	N/A
Tenancy Sustaining services – Housing Recertification and Renewals	T2040	U2, UC	N/A
Tenancy Sustaining services – Legal Services	T2040	UC, UC	N/A
Utility Assistance	T2025	UC, U3	N/A
Utility Set up – Activation Expenses	T2025	UC, U3	N/A
Utility Set up – Back Payment	T2025	UC, U4	N/A