Social Care Networks: Summary of Eligibility for Enhanced Health-Related Social Needs (HRSN) Services

As part of the New York Health Equity Reform (NYHER) 1115 Waiver Amendment, the Social Care Network (SCN) program aims to expand access to a set of health-related social needs (HRSN) services for Medicaid Members who qualify. This document provides a summary of those services as well as eligibility criteria. Please see the full SCN Operations Manual for additional details.

Overview of eligibility

All Medicaid Members, including Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MMC), can be screened for health-related social needs. The SCN program intends for all Medicaid Members to receive an HRSN screening annually or after a major self-reported life event. Medicaid FFS Members can receive navigation to existing federal, state, and local resources. MMC Members may be navigated to these existing resources or referred to Enhanced HRSN Services through an SCN in their region. Please note that service availability may vary by region.

There are four criteria for a Member to qualify for Enhanced HRSN Services:

1. Demonstrate one or more unmet HRSN, according to a State-standardized version of the Accountable Health Communities HRSN Assessment (see section 5.b. in the full SCN Operations Manual)
2. Be enrolled in Medicaid Managed Care
3. Meet one or more enhanced population criteria (see table 5-12 in the full SCN Operations Manual)
4. Meet additional clinical criteria or social risk factors if required (applies for some Enhanced HRSN Services – see more details below)

The following table summarizes the clinical criteria or social risk factor requirements by Enhanced HRSN Service type (criteria #4 in the list above). All services in the table require that criteria #1-3 be met, with one exception – 1.1 Navigation is not considered an Enhanced HRSN Service, but rather is available to any MMC of Medicaid FFS Member who screens as having an unmet HRSN (criteria #1 only).

Under Clinical Criteria, "N/A" indicates that all MMC Members who are part of an enhanced population and meet social risk factor(s) may qualify for the service.

Service	Social Risk Factor	Clinical Criteria
1) CARE MANAGEMENT FOR SOCIAL CARE SERVICES		
1.1 Navigation *(not an "Enhanced Service")*	Screens as having an unmet health-related social need	All Medicaid Members (FFS and MMC) with unmet HRSN can receive navigation
*All services below require demonstration of at least one **unmet HRSN**, enrollment in **MMC**, and meeting criteria for at least one **enhanced population***		
1.2 Enhanced HRSN care management	Screens as having an unmet health-related social need	N/A
2) HOUSING		
2.1 Home accessibility and safety modifications that are medically necessary: ramps, handrails, grab bars pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Is determined to have a need for modification and remediation services to increase and/or improve home accessibility and safety by a Social Care Navigator	• Physical disability that limits independence; and • Documentation supporting medical necessity from the individual's provider

Service	Social Risk Factor	Clinical Criteria
2.2a Home remediation services that are medically necessary: • Mold and/or pest remediation	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Requires a clinically appropriate home modification / remediation service	• Has, or is at risk for, a health condition that is exacerbated by the individual's physical living environment; and • Documentation supporting medical necessity from the individual's provider
2.2b Home remediation services that are medically necessary: • Repairing or improving ventilation systems • E.g., air conditioners, heaters, humidifiers, dehumidifier	An individual who is assessed to have unmet HRSN(s) in the housing domain; Requires a clinically appropriate home modification/remediation service; and Resides in their own home or non-institutional primary residence and an air conditioner, heater, air filtration device, and/or refrigeration unit for medications or breast milk is clinically appropriate as a health services treatment or prevention	Meets one of the clinical criteria in Part A *and* one of the enhanced populations in Part B: Part A • Chronic condition (e.g., diabetes, congestive heart failure (CHF), chronic kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, cancer, asthma, sickle cell, or HIV/AIDS); • Previous heat-related illness (e.g., 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 (e.g., hypothermia, frostbite, trench foot, or chilblains) requiring emergency room or urgent care visit within last 12 months that occurred at home; or • Individuals regularly taking medications or have an otherwise stated condition that interferes with daily thermoregulation

Service	Social Risk Factor	Clinical Criteria
		Part B • High-risk youth (as defined in enhanced population) who are under the age of 6; • Pregnant and postpartum persons (up to 12 months postpartum); • Individuals with Intellectual and Developmental Disabilities; • Individuals with Substance Use Disorder; or • Individuals with Serious Mental Illness
2.2c Home remediation services that are medically necessary: • Refrigeration units as needed for medical treatment	An individual who is assessed to have unmet HRSN(s) in the housing and/or nutrition domain; and Resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, and/or refrigeration unit for medications or breast milk is clinically appropriate as a component of health services treatment or prevention	• Prescribed medication requiring refrigeration for the management of a chronic condition; • Pregnant and postpartum (up to 12 months postpartum) that require refrigeration for breast milk; or • Enteral and parenteral nutrition (tube or intravenously feeding)

Service	Social Risk Factor	Clinical Criteria
2.3 Asthma remediation	An individual who is assessed to have unmet HRSN(s) in the housing domain; Requires a clinically appropriate home modification/remediation service; and Has a health condition that is exacerbated by the individual's physical living environment	• One or more hospital inpatient stays(s) related to asthma within the last 12 months; • Two or more ED visits related to asthma within last 12 months; • Three or more urgent care visits related to asthma within the last 12 months; • 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-procedure and post-hospitalization	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	Meets one of the criteria in Part A *or* the criteria in Part B: Part A • Requiring pre-surgical or procedure care as indicated by a medical professional; or • Admission or discharge from an acute care hospitalization related to a health condition or illness Part B • At risk for incurring other Medicaid state plan services, such as inpatient hospitalization or Emergency Department visits; or • Requiring recuperation and care for an illness or injury

Service	Social Risk Factor	Clinical Criteria
2.5 Rent / temporary housing for up to six months	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	• 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 • Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i) • Youth transitioning out of the child welfare system, including foster care
2.6 Utility setup / assistance	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Receiving rent / temporary housing for up to 6 months	• 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 • Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i) • Youth transitioning out of the child welfare system including foster care

Service	Social Risk Factor	Clinical Criteria
2.7 Pre-tenancy services (e.g., assistance with navigating the housing application, negotiating lease agreements, preparing for tenant interviews)	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	N/A
2.8 Community transitional services (e.g., security deposit, utility activation fees, pest eradication and inspection fees)	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	N/A

Service	Social Risk Factor	Clinical Criteria
2.9 Tenancy sustaining services (e.g., assistance in linking to free or affordable legal services for housing-related issues, assistance with lease renewals and housing subsidy renewals)	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	N/A
2.10 Housing transition and navigation services (e.g., assistance with set-up of a new housing unit, supporting a move, linkages to rental assistance)	An individual who is assessed to have unmet HRSN(s) in the housing domain; and Individual is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i)	N/A

Service	Social Risk Factor	Clinical Criteria
3) NUTRITION		
3.1 Nutritional counseling and education	An individual who is assessed to have unmet HRSN(s) in the nutrition domain; and Meets the USDA definition of low or very low food security because they have an unmet HRSN need in the nutrition domain	N/A
3.2a Medically tailored meals	An individual who is assessed to have unmet HRSN(s) in the nutrition domain; and Meets the USDA definition of low or very low food security because they have an unmet HRSN need in the nutrition domain	• Chronic condition (e.g., 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); or • Pregnant and postpartum persons (up to 12 months postpartum)
3.2b Clinically appropriate home delivered meals (nutritionally appropriate but may not be medically tailored)	An individual who is assessed to have unmet HRSN(s) in the nutrition domain; and Meets the USDA definition of low or very low food security because they have an unmet HRSN need in the nutrition domain	N/A

Service	Social Risk Factor	Clinical Criteria
3.3 Medically tailored or nutritionally appropriate food prescriptions	An individual who is assessed to have unmet HRSN(s) in the nutrition domain; and Meets the USDA definition of low or very low food security because they have an unmet HRSN need in the nutrition domain	N/A
3.4 Fresh produce and non-perishable groceries (pantry stocking)	An individual who is assessed to have unmet HRSN(s) in the nutrition domain; and Meets the USDA definition of low or very low food security because they have an unmet HRSN need in the nutrition domain	• Pregnant and postpartum persons (up to 12 months postpartum); or • High-risk children under the age of 18 (including justice-involved youth, foster care youth, and those under kinship care)
3.5 Cooking supplies	An individual who is assessed to have unmet HRSN(s) in the nutrition domain; and Meets the USDA definition of low or very low food security because they have an unmet HRSN need in the nutrition domain	N/A

Service	Social Risk Factor	Clinical Criteria
4) TRANSPORTATION		
Transportation related to HRSN service or care management	An individual who is assessed to have unmet HRSN(s) in the transportation domain and 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.	N/A