NEW YORK STATE | Department of Health

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

As of January 2025

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1. A NOTE ON THE SCN OPERATIONS MANUAL

Purpose of the Manual

The purpose of the SCN Operations Manual is to provide program, billing, and data governance guidance to Social Care Network (SCN) Lead Entities designated by the New York State Department of Health's (NYS DOH) Office of Health Insurance Programs (OHIP).

This guidance includes requirements governing the delivery of health-related social need (HRSN) services to New York's Medicaid Fee-For-Service (FFS) and Medicaid Managed Care (MMC) Members, as well as instructions related to data management, data security, and data sharing.

This Manual is a living document

This Operations Manual is a living document and will be updated over time. OHIP will review and refine operational guidance for the SCN program to ensure continued alignment with the State's aspiration to expand access to high-quality HRSN services. OHIP will publish updated versions of the SCN Operations Manual as they are developed. Please refer to the OHIP website for the latest version of the Manual (see "Additional Resources").

Intended audiences

SCN Lead Entities are the primary audience for this Manual, but some information may be relevant for other audiences including Community-Based Organizations (CBOs) and other HRSN service providers, Managed Care Organizations (MCOs), and health care providers (inclusive of behavioral health and primary care providers).

Additional resources that may be helpful:

For CBOs and other HRSN service providers	For health care providers
• Information for HRSN service providers website • SCN Introductory Guide for HRSN service providers • Webinar introduction for HRSN service providers (PDF)	• Information for health care providers website • SCN Introductory Guide for health care providers • Webinar introduction for health care providers (PDF)

Contact information

HRSN service providers, MCOs, health care providers, and other stakeholders: Your regional SCN Lead Entity should be the first point of contact for additional information and how to get involved (see "Awarded Social Care Networks" on SCN website).

Questions for OHIP may be directed to sdh@health.ny.gov.

2. 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 directly to Members. CBOs may or may not bill Medicaid within their organization. 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
Enhanced Services Member File (ESMF)	The Enhanced Services Member File indicates a Medicaid Managed Care Member's potential eligibility for Enhanced HRSN Services based on clinical criteria listed within this document in addition to Member information obtained during the Eligibility Assessment. Navigators must collectively use this information to determine which Enhanced HRSN Services a Member is eligible for during the Eligibility Assessment. The file pathway for the Enhanced Services Member File is from the MCO to NYeC/SHIN-NY then QEs and finally to the SCNs. The Enhanced Services Member File will be sent on a monthly basis.
ePACES	Electronic Provider Assisted Claim Entry System, a web-based application which will allow providers to create / submit claims and other transactions (e.g., Eligibility check

Term	Definition and term details
	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, and other licensed practitioners.
Homeless	As defined by U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, 4 categories of homelessness: o Literally homeless o Imminent risk of homelessness o Homelessness under other Federal regulations o 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
HL7 FHIR	Fast Health Interoperability Resources (FHIR) is a standard for health care data exchange, published by Health Level Seven International (HL7), a not-for-profit, accredited standards development organization
HRSN service provider (also "the Network" or "organizations in the Network")	Entities contracted into the SCN that conduct NYHER activities and deliver HRSN services (including but not limited to CBOs, healthcare providers, for-profit organizations, etc.) (*See Roles and responsibilities of entities within the Social Care Network and broader ecosystem for more information*)
ICD-10-CM	The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) is a standardized system used to code diseases and medical conditions (morbidity) data. Healthcare providers use ICD-10-CM codes when diagnosing patients. ICD-10-CM builds on ICD-10 (the International Classification of Diseases, Tenth Revision)— the system used to code causes of death on death certificates
LOINC	Logical Observation Identifiers Names and Codes (LOINC) is clinical terminology that provide a definitive data standard for identifying clinical information in electronic systems. LOINC is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information. One of the main goals of LOINC is to facilitate the exchange and pooling of results for clinical care, outcomes management, and research
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;

Term	Definition and term details
	• 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*)
Medicaid Eligibility File (MEF)	The Medicaid Eligibility File denotes Medicaid enrollment for FFS and Medicaid Managed Care Members as of the date it was pulled. The file is sent to SCNs via the following pathway: OHIP/MDW to NYeC, then to QEs, and finally to the SCNs. The Medicaid Eligibility file is sent on a weekly basis, and thus a Member's enrollment may be outdated at point of contact with the SCN or their Network. ePACES or MEVS Medicaid enrollment data is the most current source of Medicaid enrollment status.
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.
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*)

Term	Definition and term details
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 (*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*)
SNOMED-CT	Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT) is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of comprehensive health information. The clinical terminology is owned and maintained by the coding steward, SNOMED International, a not-for-profit association
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 connects FFS and other MMC Members to existing federal, state, or local resources. *(See Social Care Navigation for more information*)

Term	Definition and term details
Social Care Plan	Documentation of care considerations for delivery of HRSN services to eligible Medicaid Managed Care Members. Social Care Plans are developed by Social Care Navigators and intended to be longitudinal and revisited as services are rendered and needs are met. Social Care Plans are developed for Members that belong to Enhanced Services Population(s)
Social Risk Factors	After being determined to be a part of an Enhanced Population, Members are assessed by their Social Care Navigator for Social Risk Factors. For each response from the Member's screening results that identifies an unmet HRSN, the Social Care Navigator must assess the related Social Risk Factor. (*See Social Risk Factors for more information*)

3. INTRODUCTION

Introduction sub-sections:

a. Vision and goals for SCN program

b. Overview of SCN program design

c. Overview of SCN regions

d. Overview of HRSN services

e. Overview of entities in the social care ecosystem

a. VISION AND GOALS FOR SCN PROGRAM

i. Background

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

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

ii. What are Social Care Networks?

To meet that need, OHIP has established regional 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.

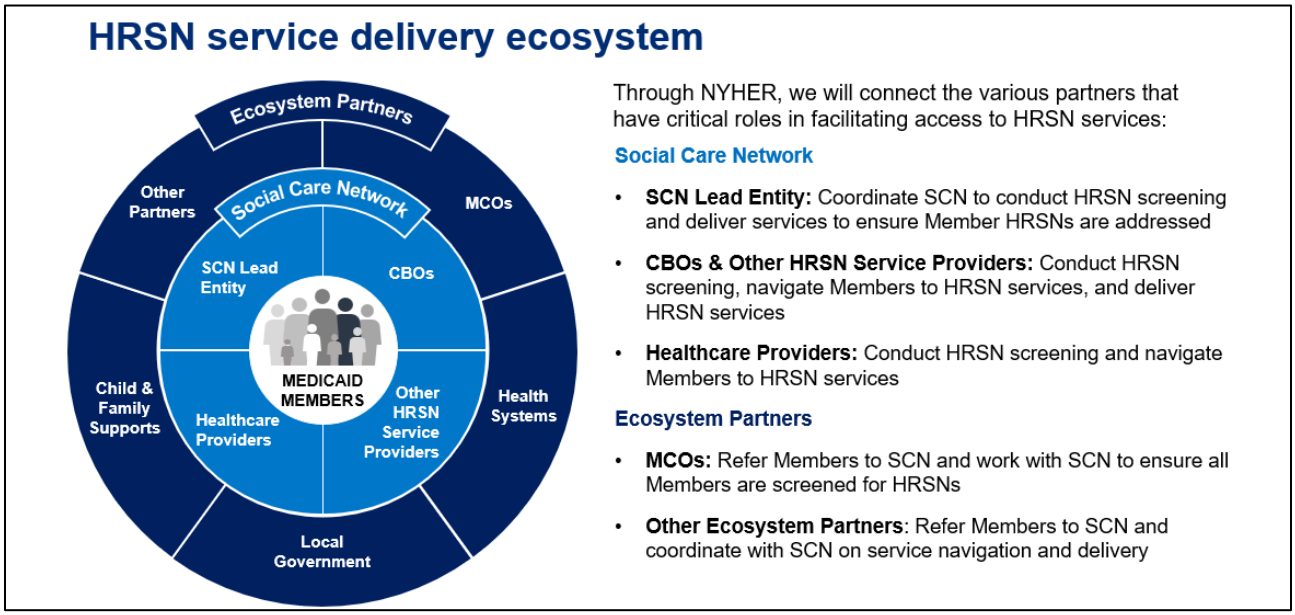
The core responsibilities of SCN Lead Entities include:

- 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. (*See SCN MEDICAID BILLING SOCIAL CARE PROVIDER DESIGNATION AND ENROLLMENT for more information*)
- Ensure more intensive coordination of HRSN services for Medicaid Managed Care Members eligible for Enhanced HRSN Services. This includes individuals who are Medicaid High Utilizers, individuals enrolled in a NYS Health Home, pregnant 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. HRSN fee schedules

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

c. OVERVIEW OF SCN REGIONS

OHIP has awarded 9 SCN Lead Entities for a contract term running from 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

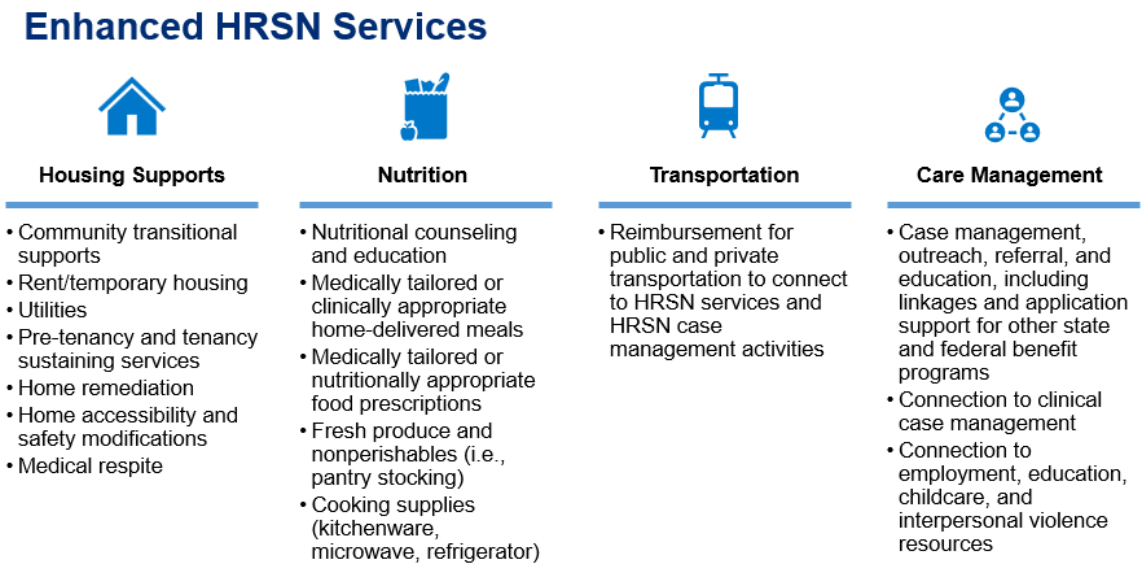
Organization	Region
Care Compass Collaborative	Southern Tier
Finger Lakes IPA Inc.	Finger Lakes
Health Equity Alliance of Long Island	Long Island
Healthy Alliance Foundation Inc.	Capital Region, Central NY, North Country
Hudson Valley Care Coalition, Inc.	Hudson Valley
Public Health Solutions	Manhattan,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

d. OVERVIEW OF HRSN SERVICES

OHIP has worked with CMS to establish criteria to determine which Medicaid Members will be eligible to receive specific, evidence-based HRSN services (e.g., housing supports, nutrition, transportation, care management) reimbursed using Medicaid dollars. These reimbursed HRSN services are referred to as Enhanced HRSN Services (*see Figure 3-2*).

Medicaid Members who have identified HRSNs but do not meet specific eligibility criteria will be navigated to HRSN services delivered by 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's intent is that SCNs will be composed primarily of not-for-profit entities providing HRSN services. However, OHIP recognizes that there may occasionally be circumstances where inclusion of a for-profit entity may be necessary to ensure timely and consistent access to Enhanced HRSN Services will need to communicate inclusion of for-profit entities in the SCN's Network Composition Plan and Report. OHIP approval is not required for inclusion of for-profit entities in the Network. OHIP reserves the right to request additional information or clarification on inclusion of a for-profit entity and to request they be excluded from the Network in the event that non-profit alternatives are able to deliver Enhanced HRSN Services. If a for-profit entity is contracted into a Social Care Network and delivers Enhanced HRSN Services but is later determined to be excluded from the SCN, they will still be reimbursed for services they have already delivered.

  (*See HRSN Network Capacity and Access.*)

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

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

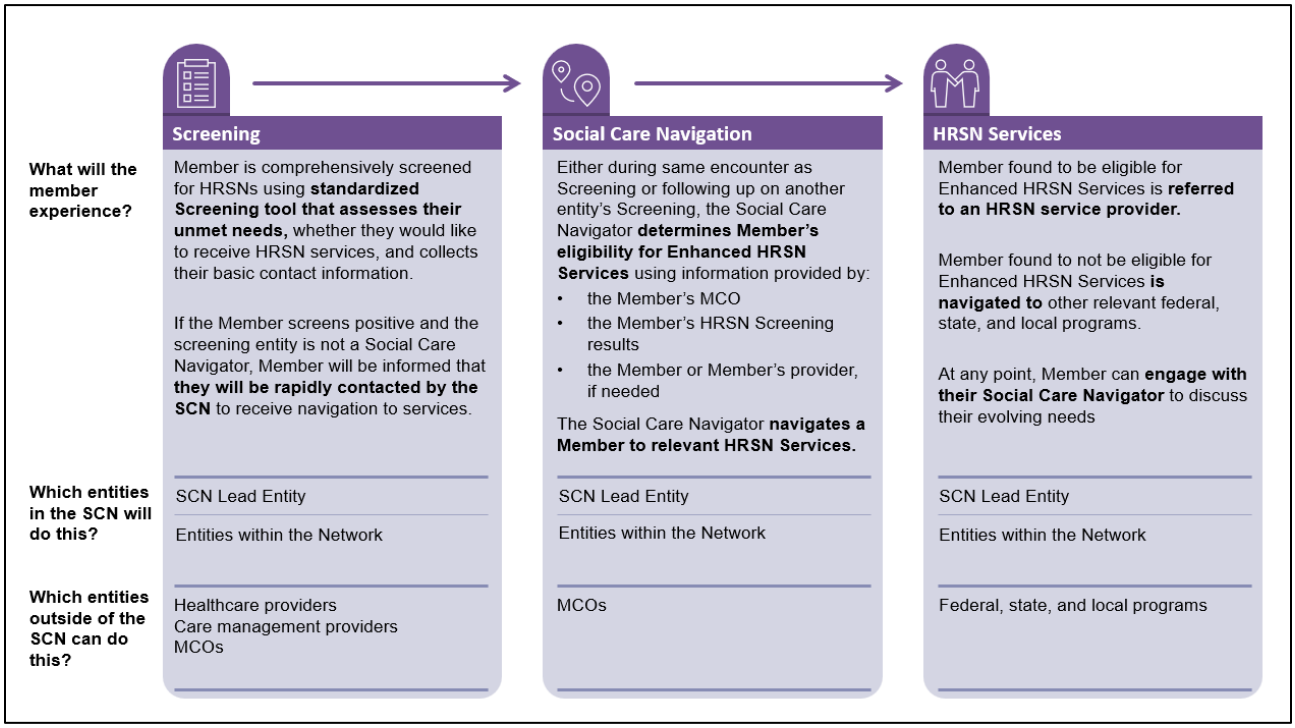
- **Health Systems and other healthcare providers:** Health system partners and other healthcare providers, inclusive of hospitals and other physical health and behavioral health providers, will continue to deliver healthcare services to Medicaid Members in their region. Healthcare providers that are 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*	a. **75%** of Medicaid population screened in between service start and 3/31/2026 b. **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 an identified unmet HRSN[2] are successfully contacted[1] within **5 business days** • Required minimum **85%** of eligible Members with an identified unmet HRSN[2] are navigated to existing federal, state, and local programs **within 7 business days** • Required minimum **85%** of eligible Members with an identified unmet HRSN[2] are referred to Enhanced HRSN 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 or automated tools (e.g., robocalls); however, Members can be navigated to an online screening tool via text message
SCN Function: HRSN Service Delivery		
Service delivery capacity	*See requirement*	• Required minimum **85%** of Referrals made to organizations are accepted[3] within **5 business days**

Service delivery continuity	*See requirement*	*No requirement at start of program:* The % of Referrals accepted for which service delivery is started will be monitored 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) Identified unmet HRSN includes indication from Member that they want to receive services
3) The Organization in the Network that gets a Referral accepts the Member and commits to providing / delivering the HRSN service

iii. Characteristics of SCNs

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

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

- *Organizational type (non-profit vs. for-profit)*: OHIP intends for Networks to be comprised primarily of non-profit entities. There may be situations in which SCNs cannot ensure sufficient capacity with existing non-profit entities. SCNs may include for-profit entities where necessary to support access provided that the SCN has already fully considered and included available non-profits capable of meeting OHIP requirements. SCNs are expected to communicate to OHIP the rationale for inclusion of a for-profit entity. OHIP does not need to approve each individual for-profit entity to be included in the SCN; however, OHIP reserves the right to request additional information or clarification on inclusion of a for-profit entity and to request they be excluded from the Network in the event that non-profit alternatives are able to deliver Enhanced HRSN Services
- *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, Mandarin Chinese, Russian, Cantonese, French, Haitian Creole, Korean, Arabic, and Bengali.

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

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

v. Accessibility of Enhanced HRSN Services

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

- **Distance to service provider**: SCNs should ensure sufficient geographic coverage to minimize travel distance required for Members to receive services.
- **Service accessibility**: Enhanced HRSN Services should be provided in appropriate accessible formats (e.g., virtual and in-person as appropriate)

vi. Ensuring broad and inclusive Social Care Networks

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

All interested / 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. Note that government entities may not be reimbursed for Screening, Navigation, or Enhanced HRSN Service delivery.

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. HRSN service provider & ecosystem partner complaints

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

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

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

viii. Expectations for capacity building

Overview of infrastructure funding: SCN Lead Entities will receive infrastructure funding to support development of the Network. Infrastructure funds can either be used directly by the SCN Lead Entity or may be distributed to CBOs . Capacity dollars are for community based organizations that are defined as not-for-profit charitable organizations providing direct Enhanced HRSN Services to Members. Health systems as defined in this manual are not eligible for capacity building dollars. SCN Lead Entities will determine distribution of infrastructure funding across CBOs based on need. (*See Infrastructure Funding section for more details*)

Use of infrastructure funding for onboarding to the SCN IT Platform: SCNs may use infrastructure dollars to assist entities that are not a CBO but are contracted with the SCN to provide access and onboarding to the IT platform and training. In addition to funding, SCN Lead Entities are responsible for providing onboarding support to contracted organizations in the Network for the following topics as needed:

- Setting up and using the SCN IT Platform
- Conducting HRSN screenings using the AHC HRSN Screening Tool
- Completing Eligibility Assessments and Social Care Plan development
- Tracking Referrals, service provision, and service completion

Distribution and use of CBO capacity-building funds: 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.

Documentation: The CBOs receiving capacity building funds from the SCN must keep receipts, records and other financial documents related to the funding for the balance of each calendar year in which they were made and for six (6) additional years thereafter. SCNs are expected to report components of their CBO capacity building in the Infrastructure Cost Report (*see SCN Reporting for details*).

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.

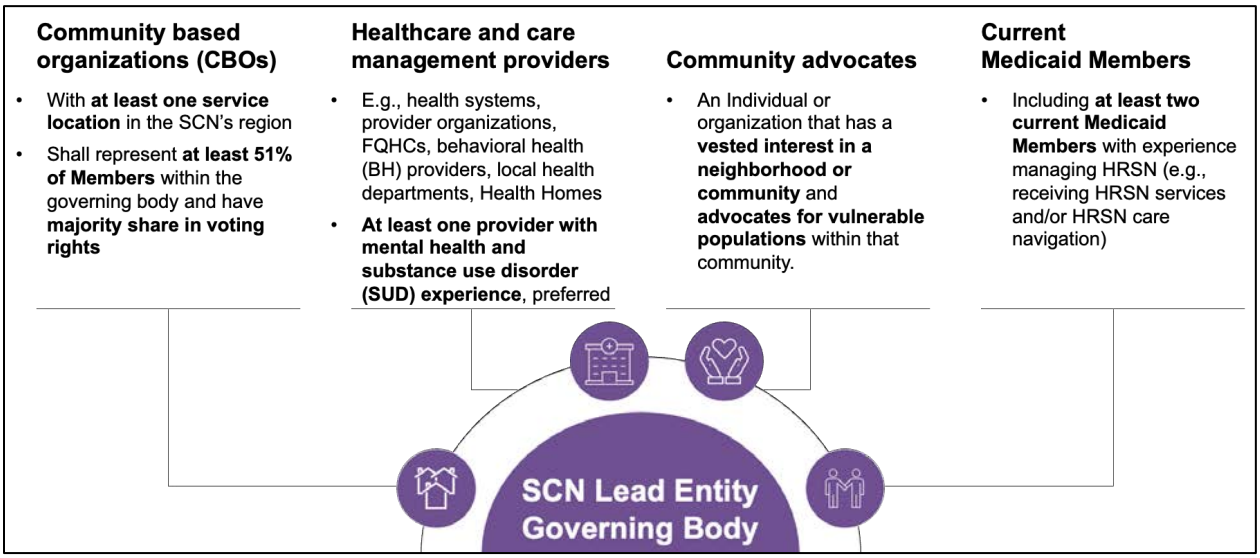
To better understand and address disparities and inequities that can impact Medicaid Members' HRSNs and their ability to access HRSN services, OHIP expects SCN Lead Entities to ensure their governing bodies include a broad and regionally representative group of individuals with diverse backgrounds and 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, and including at least one provider with mental health and substance use disorder (SUD) experience is preferred
- *Community advocates* who are collectively representative of the region and who the SCN serves
- *Current Medicaid Members*, including at least two current Medicaid Members with experience receiving HRSN services and/or HRSN Social Care Navigation. *Note that SCN Lead Entities are not expected to post publicly the names of Medicaid Members participating in the SCN Governing Body. Medicaid Member names may be posted publicly only if Members provide permission but they should not be identified as a Medicaid member.*

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

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



c. SCN IT PLATFORM REQUIREMENTS

i. Introduction to Platform Requirements

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

For example, imagine a primary care provider has a patient who is a current Medicaid Member with complex health conditions. 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. This is often referred to as "Role Based Access Controls." The SCN Lead Entity is required to manage SCN IT Platform user roles, including assigning appropriate levels of access and responsibility within the SCN IT Platform. Users should only have access to the minimum necessary information to perform their tasks as assigned.
        - Examples:
            - The HRSN service provider providing a service does not need the same level of access as a Social Care Navigator performing an Eligibility Assessment where they may need access to sensitive health information to determine Eligibility. An HRSN service provider installing handrails doesn't necessarily need information about diagnoses and eligibility status; the service provider only needs enough information to install handrails that meet the need of that Medicaid Member.
            - The HRSN service provider also does not need access to information about Medicaid Members for whom it does not provide 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 has an identified 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 HRSN fee schedule for services delivered, enable generation of social care claims, and track reimbursements
- **Performance management:**
    - Generate supporting information (e.g., performance dashboards) for SCN quarterly performance reporting requirements to OHIP and enable continuous improvement activities across SCNs
- **Data sharing and exchange:**
    - Facilitate bi-directional exchange of data with SHIN-NY (which will play a central role in SCN program operations) and enable near real-time data sharing across key program stakeholders. SCN IT Platforms should be able to incorporate eligibility files from MCOs via the SHIN-NY and into the SCN IT Platform to support the Eligibility Assessment

process. (*For 1115 SHIN-NY Interoperability Guidance, SCN Lead Entities and their SCN IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/*)

- Include support terminology and the minimum viable data
- Exhibit FHIR competency

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

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

Category	Minimum features / functionalities
Referral and service delivery	• Maintain up-to-date, accurate, and publicly available HRSN service Resource Directory (e.g., name, location, EIN, services provided, contact information) • Conduct Closed Loop Referrals to organizations within the SCN that deliver Enhanced HRSN Services. Referral details should include HRSN services for which Referral was made, which HRSN service provider a Member was referred to, whether Referral is open / closed, time from when Referral is made to when service delivery is initiated, and any specifications of the service • Allow input of the Eligibility Assessment and case notes related to social care into a Social Care Plan and sharing of case notes (as needed) with MCOs and providers • Track completion of services and service details to inform coordination and generation of invoice / claim for services • Track current and historical Member service delivery experience details (e.g., prior services delivered to Member and associated details) • Maintain ability to incorporate external provider directories (via application programming interface with MCOs) • Capture and share information with Social Care Navigators on ability of HRSN Service Providers to receive Referrals and provide Enhanced HRSN Services based on their capacity
Payment and fiscal administration	• Generate social care claims including service detail • Track status of claims submission and process electronic data interchange transactions • Track HRSN fee schedule-based reimbursement from SCN Lead Entities to entities within the Network • Maintain up-to-date HRSN fee schedule to inform claims generation
Performance management	• Generate performance reports that meet State requirements • Generate Network-level summary data (e.g., number of participating HRSN service providers, activity by HRSN service provider, summary of services delivered, etc.)
Data sharing and exchange	• Conduct near real-time and batch bi-directional exchange of data with SHIN-NY (through subscription query capability) • SCN Lead Entities and their SCN IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/ 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. Background on coding granularity

During the eligibility assessment and when making referrals, Social Care Navigators will be required to document granular ICD10 and SNOMED codes that capture the specific nature of navigation support provided by the Navigator and specific enhanced HRSN services to which Members are referred. OHIP recognizes that this coding will require additional time for Navigators to input. Accurately coding navigation activities and HRSN service referrals is critical for both SCNs and OHIP to conduct ongoing monitoring of SCN activities, including accurately tracking referrals to and spend on various services, and to enable long-term program sustainability. In addition, granular coding will enable evaluation of the impact of the SCN program and inform design of subsequent HRSN programs and risk scoring methodology.

Wherever possible, OHIP encourages SCNs and SCN IT Platform vendors to automate coding to ensure time required from Navigators is minimized.

Social Care Coding Automation and Display in SCN IT Platforms

The SCN IT Platform shall auto-populate a filtered set of coding options for each of the Eligibility Assessment and Navigation activities (e.g., referral and delivery of Enhanced HRSN services) based on the Member's specified needs as identified via the screening tool.

Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the live social care coding documents referenced below on NYeC's NYHER 1115 Extranet.

Eligibility Assessment

ICD10/SNOMED coding

- The SCN IT Platform should populate only the ICD10 and SNOMEDCT assessment code(s) associated with the Member's screening response(s) in the Eligibility Assessment for the Navigator to document.
    - For example, if the Member's HRSN Screening demonstrates a positive need for "Mold" (Question #2 response) and "Help keeping work" (Question #7 response), the platform should only suggest codes "Other inadequate housing" (Z59.19)/"Mold growth in home" (224255009) and "Unspecified problems related to employment" (Z56.9)/ "Employment problem" (75148009), respectively for the Navigator to document. Other coding options should not be populated given no other unmet HRSN identified.
    - Please reference the NYeC Extranet to view the latest Excel "Social Care Coding","Screening to Assessment Mapping" tab
    - The IT Platform should use the same description and code strings for ICD10 and SNOMEDCT assessment code options as they appear in the "Social Care Coding", "Assessment- ICD & SNOMED" tab.

Social Care Navigation

SNOMED coding

- The SCN IT Platform must first consider whether the Member is eligible for Navigation or Enhanced Services before making a recommendation on HRSN services (see criteria in Table 5-4: Populations eligible for Navigation and Enhanced HRSN Services)
    - Members who are assessed to be eligible for Navigation should be offered the following per the "Social Care Coding" workbook:
        - All Navigation SNOMED codes found in the "Services-SNOMED" tab .
    - Members who are assessed to be eligible for Enhanced Services should be offered the following per the "Screening to Services" workbook:
        - All Enhanced Care Management Services within the red box in the "Care Management" tab
        - All Enhanced Care Management services in the "Care Management" tab associated with the specific questions to which the Member screened positive (i.e., listed below the red box)
        - All HRSN service SNOMEDs associated with each positive screening response for the Member (located on the domain-specific "Housing," "Nutrition," and "Transportation" tabs).
            - For example, if the Member's screen demonstrates a positive need for "Mold" (Question #2 response), in addition to the relevant Care Management options, the following five domain-specific services should be offered with the respective SNOMED codes (see table 4-3 below)

Please reference the NYeC Extranet to view the latest Excel "Social Care Coding" and "Screening to Services Mapping" documents for all coding guidance

Table 4-3: Example enhanced services screening to services codes mapping

SNOMED Description	SNOMED Code
Provision of payment for housing mold remediation fee (procedure)	851331000124101
Dwelling Assessment for Home Modifications and Remediation	0010001
Provision of payment for medically necessary home modification (procedure)	841231000124107
Provision of payment for housing pest control fee (procedure)	841201000124104
Remediation of asthma triggers in residence (procedure)	1340000005

v. Data Sharing - Interoperability

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

SCN Lead Entity responsibilities include:

- Agree to share data elements as defined in the minimum viable data set with the QE and send data to the QE who will then submit data on behalf of the SCN Lead Entity to the NYeC/SHIN-NY data lake
- In coordination with a QE, establish a user process and technical means to obtain data from the SHIN-NY via a real-time API call to the SHIN-NY data lake
- Ensure the SCN IT Platform vendor can display Medicaid Member files and flag eligibility (e.g., Member information, Enhanced Services eligibility)
    - Medicaid Eligibility files will be sent from the SHIN-NY to SCN Lead Entities
- consensus-based terminology and coding standards for social care and payment data including, but not limited to, LOINC codes, ICD-10 Z-codes, SNOMED-CT codes, HCPCS codes, CBO identifiers (e.g., TIN)
- Ensure SCN IT Platform ability to submit Social Care Claims to MCO in a format that meets HIPAA post-adjudicated claims standard (i.e., 837 EDI transaction) for payments
- Meet HL7 FHIR national standards for bi-directional data sharing and data transactions between the SCN Lead Entity and QE in accordance with 1115 SHIN-NY Interoperability Guidance
- Define approach to aligning data quality standards and validation processes with existing federal and state data standards

vi. Data Governance, Privacy, and Security

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

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

d. TRAINING EXPECTATIONS

SCN Lead Entities are responsible for ensuring that all SCN employees, HRSN service providers, other entities in the Network, and MCOs (if MCOs choose to participate in Screening, Eligibility Assessments, and 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 outlined in 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 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 providing information on the Network on or before 1/1/2025 as indicated in the SCN Lead Entity's contract with OHIP.

The SCN public website is expected to include:

- **Basic introduction to SCN and services offered**: Guidance to public audience on services provided by the SCN and Member eligibility
- **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 Screening information, support with accessing SCN resources)
- **Network organization directory:** Up-to-date, publicly available SCN directory that includes all contracted HRSN service providers (*see SCN Reporting for details on data elements that must be included in the quarterly Network Composition Report*)
- **HRSN screening locations:** Relevant contact information for each screening location (e.g., address, hours, languages spoken, screening modalities offered, etc.)
- **Self-screening capability:** HRSN screening tool for Members to conduct a self-screen must be available on the SCN website
- **Language translation:** It is up to the discretion of the SCN Lead Entity to determine languages in which key information on the SCN website will be made available. OHIP encourages SCNs to make materials available in the languages that are common and preferred by Medicaid populations of the region (*see HRSN Network Capacity and Access*)
- **Governing body:** The SCN Lead Entity shall post a list of Governing Body members on the SCN website. SCN Lead Entities are not expected to post publicly the names of Medicaid Members participating in the Governing Body. Medicaid Member names may be posted publicly only if Members provide permission, *but they should not be identified as a Medicaid member*. Additional details (e.g., meeting minutes) do not need to be posted on the website (*see Governance Requirements*)

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

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

f. PUBLIC MATERIALS ON SCN PROGRAM

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

To encourage consistent messaging and ensure accuracy, OHIP asks SCNs to leverage OHIP-developed materials in recruiting providers and engaging Members. The marketing toolkits provided will have clear direction on areas for customization and co-branding. In the meantime, SCNs may proactively engage local stakeholder communities to provide transparency on launch preparation efforts – OHIP understands that involves creating direct channels of communication for each SCN's unique audiences.

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

5. CARE DELIVERY APPROACH

Care delivery approach sub-sections

a) Introduction

b) Screening

   i. HRSN screening overview
   ii. Who will conduct HRSN screening
   iii. Handoffs to SCN for screening
   iv. Screening methodology
   v. AHC HRSN Screening Tool
   vi. Screening in the SCN IT Platform
   vii. Screening conducted outside the SCN IT Platform
   viii. Considerations for interpersonal safety questions asked during screening

c) Social Care Navigation

   i. Social Care Navigators
   ii. Reimbursement for social care Navigation
   iii. Navigation process

d) Eligibility Assessment

   i. Medicaid Member Eligibility
   ii. Eligibility Assessment Process
   iii. Considerations for children, youth, and households
   iv. Considerations for criminal justice-involved individuals and justice-involved youth
   v. 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. Eligible Population, Social Risk Factors, and Clinical Criteria by service
    v. Criteria documentation and attestation
    vi. Covered HRSN Services
    vii. 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.

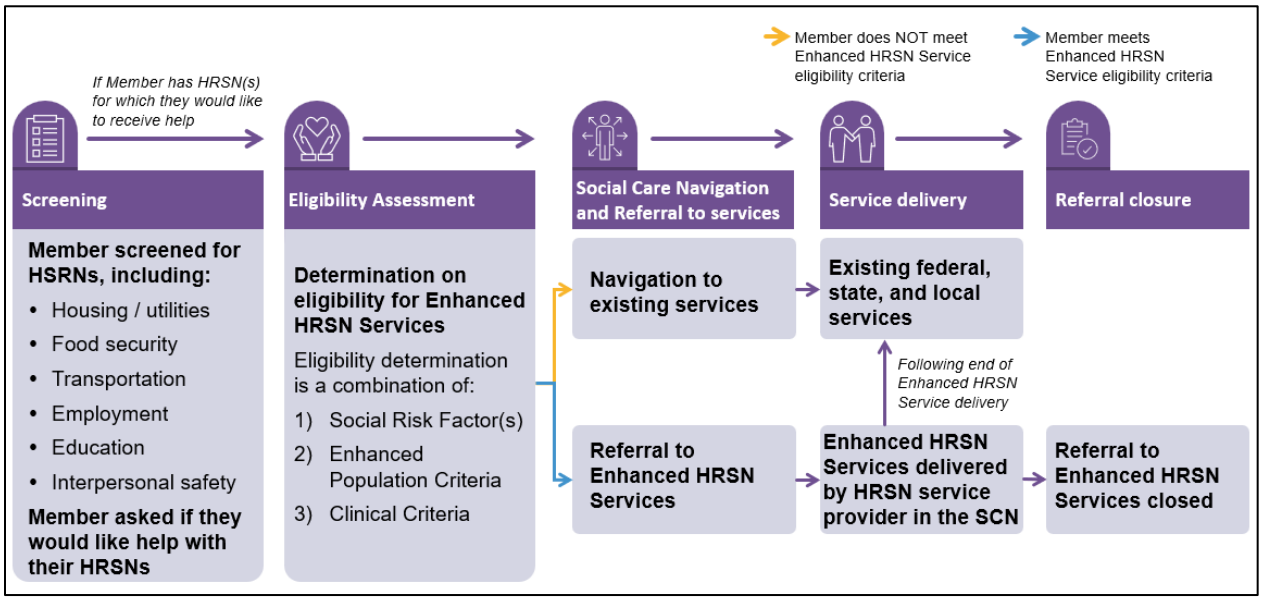
Towards that vision, SCNs will be responsible for administering a core set of responsibilities using standardized processes, tools, and partnerships to ensure consistency and equity in how HRSNs are identified and addressed at scale across regions and across many different HRSN service providers.

The core responsibilities of SCNs are:

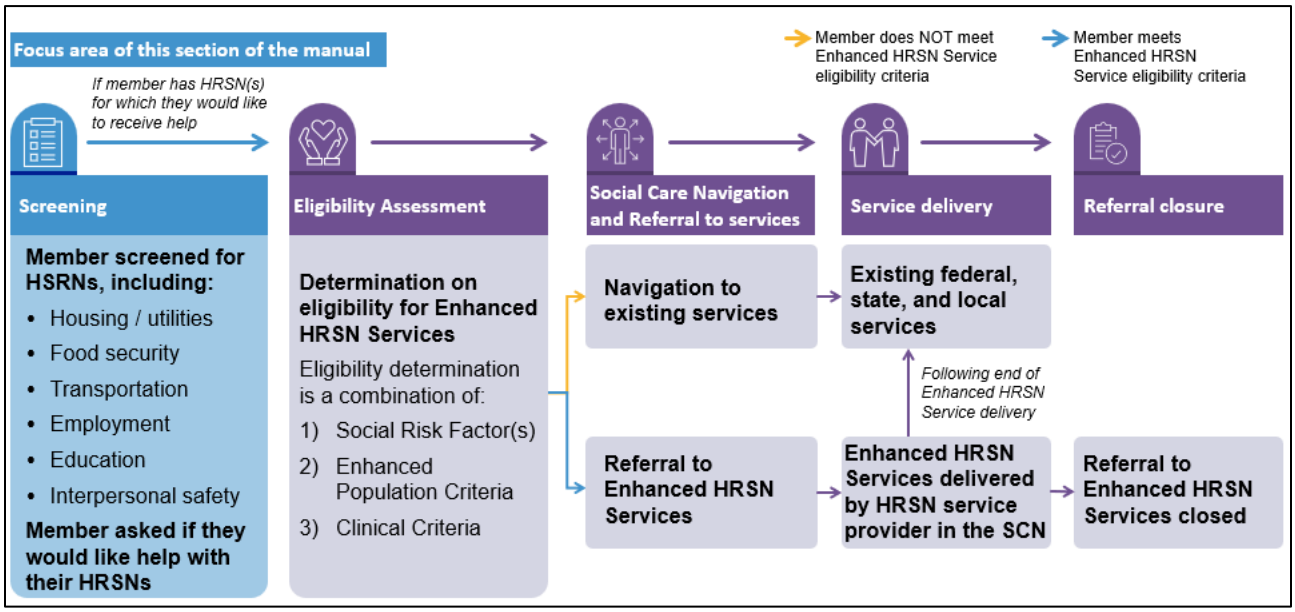
a) **Screen Medicaid Members for HRSNs** in a standardized and person-centered way using the OHIP-standardized version of the Accountable Health Communities (AHC) HRSN screening tool
b) **Conduct Eligibility Assessments** for Members whose screening identifies unmet HRSNs and who request support. Eligibility 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 Enhanced HRSN Services** to eligible Medicaid Managed Care 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 have an identified unmet HRSN 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 identified unmet HRSNs with care and empathy, including offering time to discuss their needs and potential next steps (e.g., Eligibility Assessment, Referral).

(*For more information on screening capacity and capabilities, see HRSN Network Capacity and Access*)

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 from the initial Screening (in the absence of a major life event) are NOT eligible for reimbursement.

Table 5-1: Frequency of HRSN Screening

Reason for screening	Details
Annual screening	Members will be eligible for reimbursed HRSN Screening annually.
Major life event	Members will also be eligible for reimbursed HRSN Screening if a major life event occurs. If the Screener identifies a Major Life Event during their interaction with the Member, or if a Member was referred to the SCN for a Screening as a result of a Major Life Event, the Member may be re-screened within the same year and the Screener may be reimbursed for the re-screen. A major life event is a permanent or fluctuating event in a Member's life that may be identified by any contracted entity within the SCN that is authorized to have direct contact with a Member (e.g., through Screening, Eligibility Assessment, HRSN service delivery, service follow-up). Members will be eligible for their annual screening 12 months after their original Screening date, regardless of any re-Screens due to a Major Life Event. Major life events may include:

	• Change in functioning (including an increase or decrease of symptoms or a new diagnosis); • Inpatient or outpatient hospital admittance and/or discharge; • Serious injury; • Admittance, discharge, or transfer from detox or residential placement; • Significant change in housing, including move to a different SCN region, move to different housing, or loss of housing; • Significant change in income or support resources; • Significant change to family, including but not limited to: marriage or divorce; giving birth (regardless of outcome) to or adopting a child, loss of a family member; • Arrest; • Loss of benefits

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 wording and LOINC coding as the AHC Tool for question-and-answer pairs. Questions cannot be adjusted or changed. SCNs should reach out to OHIP Contract Managers to speak with NYHER data subject matter experts before conducting any proposed mappings to the LOINC coding in the AHC Tool.

- *Be complete: In order for a screening to be reimbursed, the screening data elements with an asterix in Table 5-3* must be collected. While screeners should ask all questions in the screening tool, OHIP recognizes that Members may not feel comfortable answering every question. If a Member does not wish to answer a particular question, the screener should record "Decline to answer" as the answer, and questions will 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 or QE.

- *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 5-1 for list of major life events). Members can receive up to 1 reimbursed re-screen per year following their initial Annual Screening.

- *Involve 1:1 Member interaction:* Screening must include a 1:1 interaction between the Screener and Member for 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: OHIP's vision is for New York State to be a healthy community of thriving individuals and families. To advance that vision, OHIP is deeply committed to SCNs strengthening the physical, mental, and social well-being of New York's children and youth. Children and youth participating in New York's SCN program will experience a similar Member journey to adult participants: they should be screened for unmet HRSNs, connected with appropriate HRSN services, receive services and social care planning, and receive follow-up to determine whether their HRSNs have been addressed and if ongoing services are needed.

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

- *Expectations for screening minors:* As with adult Medicaid Members, SCNs are responsible for screening all children and youth enrolled in Medicaid for unmet HRSNs using the same

standardized 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:* OHIP does not require a child-specific training for HRSN screeners. However, all Screeners are expected to complete the list of trainings suggested in the Training Expectations section, including trauma-informed training.

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

- *Screening documentation for children:* As for adults, all screening responses are required to be entered into the SCN IT Platform (either directly or through a platform capable of sharing data with the SCN IT platform). Platforms are not required to capture a data element for the name / relationship of the person who completed the Screening on a child's behalf. However, SCNs are expected to include this in the 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 the required AHC HRSN Screening Tool to assess needs across a range of HRSN domains. These screenings will contain questions related to six HRSN domains: housing and utilities, 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.

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

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

Each answer to screening questions has a corresponding LOINC code that is used to determine if the Screening is positive *(for an overview of these LOINC Codes, see Screening for Social Risks: LOINC Codes).*

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

SCN LEs and their IT platform vendors should refer to the MVD and 1115 SHIN-NY FHIR IG for a comprehensive list of screening data elements to configure their systems. Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to the live social care coding documents. A new document entitled, "Screening Question and Response Coding," contains the FHIR-aligned coding associated with the Screening data elements. Table 5-3 in Section vii. (below) is a version if the document without associated coding. It is not a comprehensive list for IT platform configuration (see MVD and 1115 FHIR IG for this). Nonetheless, Table 5-3 can be helpful to SCN Lead Entities and their SCN IT Platforms to see a snapshot of most screening data elements in one place since the MVD does not offer this view. The Screening Question and Response Coding document and Table 5-3 are primarily resources for screening entities conducting screens outside of an SCN IT Platform who do not have access to the MVD.

Note, for entities screening inside and outside the SCN IT platform the following is true: All screening data elements are required for configuration. The data elements with an asterix on Table 5-3 must be completed in full during the Screening activity and are required for reimbursement. Collection of the other Screening Data elements (i.e., demographics, physical disability) is required for completion and must be initiated during the Screening activity but can be finished in future steps of the NYHER member journey if need be.

The SCN IT Platform will house HRSN screening data for Members who are screened by the SCN, including but not limited to:

- *Member contact information, member identifiers* including name, address, phone number, and email (if available)
- Screener Identifiers, unique screening interaction identifiers assigned to a screening entitiy type, including screening entity IT and type
- *Member's HRSNs across the six domains covered by the Screening Tool*. AHC HRSN Screening Tool questions and responses will be mapped using LOINC codes. LOINC codes will be mapped to reasonable ICD 10 CM and SNOMED codes following the assessment
- *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
- *Data about demographics and physical disability*
    - At the time of the Screening interaction, the Navigator should engage with the Member to initiate gathering their responses on the following set of Demographic and Physical Disability questions built into the SCN IT Platform (based on OHIP's Minimum Viable Dataset).

Demographics

- *What is the Member's administrative gender?*
    - Please reference the following resources for available response options: https://hl7.org/fhir/valueset-administrative-gender.html
- *What is the Member's gender identity?*
    - Please reference the following resources for available response options: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1021.32/expansion
- *What is the Member's preferred pronouns?*
    - Please reference the following resources for available response options: https://shinny.org/us/ny/hrsn/ValueSet-SHINNYPersonalPronounsVS.html
- *What is the Member's sexual orientation?*
    - Please reference the following resources for available response options: https://vsac.nlm.nih.gov/valueset/2.16.840.1.113762.1.4.1240.11/expansion
- *What is the Member's ethnicity?*
    - Please reference the following resources for available response options: https://hl7.org/fhir/us/core/STU3.1.1/StructureDefinition-us-core-ethnicity.html
- *What is the Member's race?*
    - Please reference the following resources for available response options: https://hl7.org/fhir/us/core/STU3.1.1/StructureDefinition-us-core-race.html
- *What is the Member's preferred language spoken?*
    - Please reference the following resources for available response options: https://hl7.org/fhir/R4/valueset-languages.html

Physical Disability

Please reference the following resources for available response options: http://shinny.org/us/ny/hrsn/Questionnaire/SHINNYDisablityQuestionnaire

- *Does the Member have serious difficulty walking or climbing stairs (5 years old or older)?*
- *Does the Member have difficulty dressing or bathing (5 years old or older)?*

vii. Screening conducted outside the SCN IT Platform

Contracted Screening entities can be reimbursed to Screen using unique screening IT platforms or Electronic Health Record Systems (EHRs) independent from the SCN IT Platform if the system in which the screening is conducted is interoperable with the SCN IT Platform and screenings use the AHC HRSN Screening Tool or another assessment instrument with identical wording and LOINC coding as the AHC

Tool for question-and-answer pairs. This allows data to be seamlessly integrated into the SCN IT Platform and ingested by the SHIN-NY.

For example, an ambulatory practice functioning as an SCN Screening entity may screen via their EHR, then contribute NYHER compliant screening data to their regional QE. This will allow data to seamlessly flow to the SCN IT Platform in the daily screening data extract and later be ingested by the SHIN-NY.

Social Care Providers using platforms other than the SCN IT Platform to screen may receive payment for Screening if the screening entity collects all screening data elements outlined in Table 5-3 with an asterix and is contracted with the SCN Lead Entity. See the Screening Methodology section, sub-section Reimbursement for Screenings, and the screening data elements with an asterix on Table 5-3 (below) for *the fields required for reimbursement.*

All screening data elements collected outside the SCN's IT platform should flow seamlessly from said platform to NYeC's SHIN-NY to the SCN's regional QE to the SCN's IT platform.

Since the NYHER program requires the use of coding and exchange data standards, it remains agnostic to specific assessment instruments and IT platforms, if the required terms described in this guidance are implemented. This ensures the data utilized in the program is open source and accounts for the existing infrastructure that health and social care ecosystem partners already have in place.

Below is a table of the complete list of the screening data elements that Screening entities conducting screenings outside the SCN IT Platform must collect and send to the SCN IT Platform via the SHIN-NY and QE. Table 5-3 is not a comprehensive list of screening data elements and therefore should not be referenced exclusively for SCN IT platform configuration (SCN LEs and their IT platform vendors should see the MVD and 1115 SHIN-NY IG for this purpose).

Table 5-3: Required data elements for screenings conducted outside the SCN IT Platform

*Indicates a required field for data submission to receive reimbursement

Item	Question	Response
Screening Entity Responses		
Type*	Screening Entity Type	Healthcare Provider
		Hospital Department
		Organizational Team
		Government
		Insurance Company
		Payer
		Educational Institute
		Religious Institution
		Clinical Research Sponsor
		Community Group
		Non-Healthcare Business or Corporation
		Other
ID*	Screening Entity ID	*Screener's TIN, FEIN, or NPI*

Name*	Name of entity conducting the screening	*Cannot be NULL*
Address 1*	Address Line 1 that the Screening Entity is located	*Cannot be NULL*
Address 2	Address Line 2 that the Screening Entity is located	
City*	City that the Screening Entity is located	*Cannot be NULL*
Postal Code*	Postal Code that the Screening Entity is located	*Data Format: 5 digits*
County*	County that the Screening Entity is located	*Data format: Text*
State*	State that the Screening Entity is located	*Data format: 2 Characters*
Screen Identifier*	Unique interaction identifier assigned to a screening.	
Screen Language*	Language in which the screening was conducted.	*See response options for "Spoken Language", below*
NYS HRSN Parent Local Code*	Local code to identify the provision of the NYS-specific interaction of the AHC screening.	NYSAHCHRSN
Screen Domains*	Social care needs domain reflective of Gravity Project social history categories for AHC HRSN questions.	Housing Instability
		Homeless ness
		Inadequate Housing
		Utility Insecurity
		Food Insecurity
		Transportation Insecurity
		Employment Status
		SDOH Category Unspecified
Screen Potential Unmet Risk*	Local code to identify the provision of the NYS-specific interaction of the AHC screening.	*LOINC response codes from AHC Screening (below) for which the patient indicated positive need*
Member Responses		
Question 0*	*We use this survey to understand needs our [Members / patients / clients] have which could interfere with good health. We may share your answers with your other healthcare providers, and with your health plan and social services organizations, so they can determine if you qualify for any free non-medical services that could be helpful. Please check this box if you agree to continue. You can choose not to answer this survey, but we can only check for services if you do answer.*	Permit
		Deny
Medicaid Client Identification Number (CIN)*	Unique identification number assigned by NYS Medicaid Program to a patient at time of initial enrollment through either the county or NYSoH.	*Data Format: AA00000A*
Medical Record Number (MRN)*	Unique identification number assigned by the organization who screens the patient and used to identify the patient within the organization's records.	*Content may vary from different sources.*
Social Security Number (SSN)	Unique identification number assigned by the Social Security Administration to a patient.	*Cannot be NULL* *Data Format: 999999999*
Patient Last Name*	Patient's last name, reported by patient at time of interaction.	*Cannot be NULL*
Patient First Name*	Patient's first name, reported by patient at time of interaction.	*Cannot be NULL*

Patient Middle Initial	Patient's middle initial, reported by patient at time of interaction.	
Date of Birth*	Patient's date of birth	*Data format: DD/MM/YYYY*
Sex*	Patient's administrative gender, reported by patient at time of interaction.	Male
		Female
		Other
		Unknown
Patient Address Line 1*	Patient's residential county street address, reported by patient at time of interaction.	*Cannot be NULL*
Patient Address Line 2	Patient's residential county street address, reported by patient at time of interaction.	
Patient City*	Patient's residential county city, reported by patient at time of interaction.	*Cannot be NULL*
Patient Postal Code*	Patient's residential county postal code, reported by patient at time of interaction.	*Cannot be NULL* *Data format: 5 digits*
Patient County*	Patient's residential county, reported by patient at time of interaction.	*Cannot be NULL* *Data format: text*
Patient State*	Patient's residential state, reported by patient at time of interaction.	*Cannot be NULL* *Data format: 2 characters*
NYS Accountable Health Communities (AHC) Health-Related Social Needs Screening (HRSN) Tool	1. What is your living situation today?*	I have a steady place to live
		I have a place to live today, but I am worried about losing it in the future
		I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
	2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY*	Pests such as bugs, ants, or mice
		Mold
		Lead paint or pipes
		Lack of heat
		Oven or stove not working
		Smoke detectors missing or not working
		Water leaks
		None of the above
	3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home*	Yes
		No
		Already shut off
	4. Within the past 12 months, you worried that your food would run out before you got money to buy more.*.	Often true
		Sometimes true
		Never true
	5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.*.	Often true
		Sometimes true
		Never true
	6. In the past 12 months, has lack of reliable transportation kept you from medical	Yes

	appointments, meetings, work or from getting things needed for daily living?*	No
	7. Do you want help finding or keeping work or a job?*	Yes, help finding work
		Yes, help keeping work
		I do not need or want help
	8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.* .	Yes
		No
	9. How often does anyone, including family and friends, physically hurt you?	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	10. How often does anyone, including family and friends, insult or talk down to you?	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	11. How often does anyone, including family and friends, threaten you with harm?	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	12. How often does anyone, including family and friends, scream or curse at you?	Never (1)
		Rarely (2)
		Sometimes (3)
		Fairly Often (4)
		Frequently (5)
	13. Safety Score	Sum of response values 9-12
Gender	What is the Member's gender identity?	Female Gender Identity
		Male Gender Identity
		Non-Binary Identity
		Asked but Declined
		Unknown
Preferred Pronouns	What are the Member's preferred pronouns?	He/Him/His/His/Himself
		She/Her/Hers/Herself
		They/Them/Their/Theirs/Themselves
		Other
		Unknown
Sexual Orientation	What is the Member's sexual orientation?	Bisexual
		Heterosexual
		Homosexual

		Other
		Asked but Unknown
		Unknown
		Decline to Answer
Ethnicity	What is the Member's ethnicity?	Hispanic or Latino
		Not Hispanic or Latino
		Asked but Unknown
		Unknown
Race	What is the Member's race?	American Indian or Alaska Native
		Asian
		Black or African American
		Native Hawaiian or Other Pacific Islander
		White
		Asked but Unknown
		Unknown
Spoken Language	What is the Member's preferred language spoken?	Arabic Bengali Czech Danish German German (Austria) German (Switzerland) German (Germany) Greek English English (Australia) English (Canada) English (Great Britain) English (India) English (New Zeland) English (Singapore) English (United States) Spanish Spanish (Argentina) Spanish (Spain) Spanish (Uruguay) Finnish French French (Belgium) French (Switzerland) French (France) Frysian Frysian (Netherlands) Hindi Croatian Italian Italian (Switzerland) Italian (Italy) Japanese

		Korean Dutch Dutch (Belgium) Dutch (Netherlands) Norwegian Norwegian (Norway) Punjabi Polish Portuguese Portuguese (Brazil) Russian Russian (Russia) Serbian Serbian (Serbia) Swedish Swedish (Sweden) Telegu Chinese Chinese (China) Chinese (Hong Kong) Chinese (Singapore) Chinese (Taiwan)
Physical Disability	Does the Member have serious difficulty walking or climbing stairs (5 years old or older)?	Yes
		No
		Decline to Answer
	Does the Member have serious difficulty dressing or bathing (5 years old or older)?	Yes
		No
		Decline to Answer

viii. Considerations for interpersonal safety questions asked during screening

While a Member may receive an interpersonal safety score below the threshold needed to identify the Member as having an unmet HRSN regarding safety (e.g., due to Member not answering all 4 interpersonal safety questions), the Member may still benefit from support related to interpersonal safety. When appropriate, Navigators may consider navigating a Member to existing local, state, or federal resources for interpersonal safety support, even if their safety score is not above the threshold.

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

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

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

- *Be conducted on behalf of a Medicaid Member:* Only navigation of enrolled Medicaid Members (both FFS and Managed Care Members) will receive reimbursement.
- *Be conducted by a Social Care Navigator:* Service must be delivered by Social Care Navigator; Social Care Navigators may include employees of the SCN Lead Entity or of organizations that are contracted as part of the Network. Navigation will not be reimbursed if conducted through an automated program or website.
- *Be time spent engaging with the Member or on behalf of the Member:* Social Care Navigators will only be reimbursed for time spent with a live person (on the phone, in person, virtual) engaging with a Member or other stakeholders (e.g., guardian, clinical provider) on behalf of the Member with regards to eligibility or care coordination.
- *Be conducted using the SCN IT Platform or system that is able to send referral information to the SCN IT Platform:* The Social Care Navigator must send the referral information either through

the SCN IT platform or through an integrated or interoperable application that is able to incorporate referral information into the SCN IT platform. For example, if a provider has a different IT system from the SCN but has an EHR module from that system and is able to send referral data to the SCN's platform or the SCN platform is able to receive data via FHIR integration, navigation can be reimbursed.

- *Be documented in the Social Care Plan*: Details of Navigation to Enhanced HRSN Services, including any questions asked during the assessment, must be documented in the Member's Social Care Plan.

iii. Navigation Process

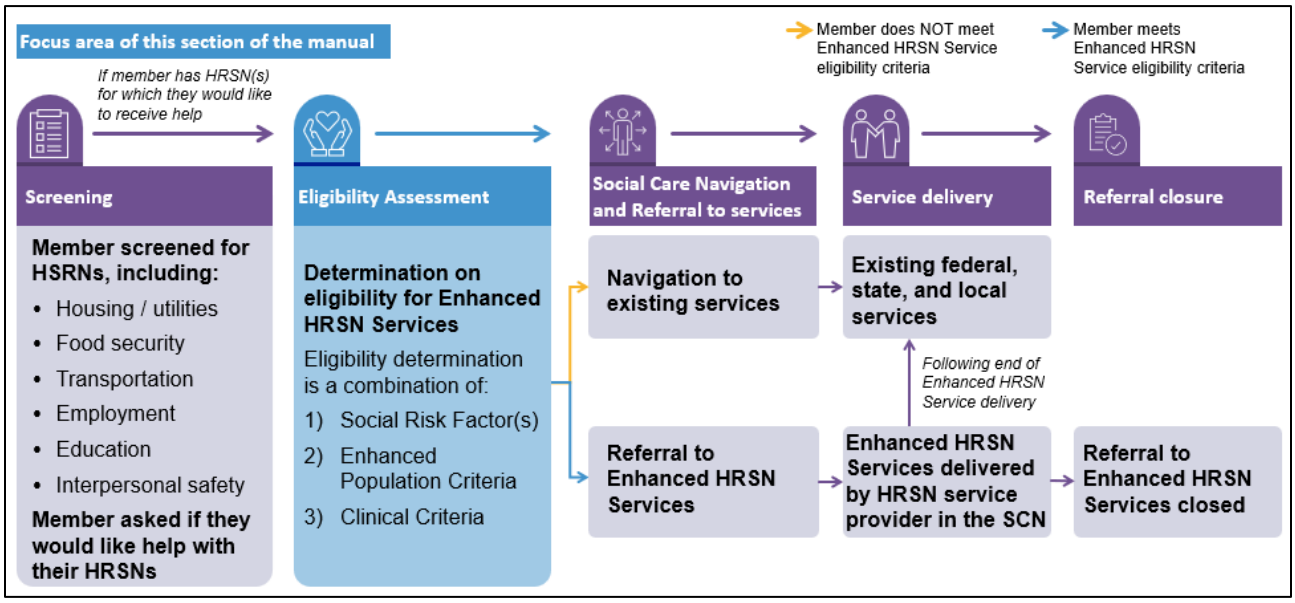
The Navigation process includes validating Member eligibility for Enhanced HRSN Services, managing Closed Loop Referrals for HRSN Services, and developing Social Care Plans for eligible Medicaid Managed Care Members.

Eligibility Assessment. This includes 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. The enhanced population will be navigated under HRSN Care Management.

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. 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 the 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 Screening and 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
        - Members who are permanently placed in Nursing Home evaluation

        - Individuals residing in a state Office of Mental Health facility
        - Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center
        - Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention (CDC) breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage

- **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 5-4 below as determined during an Eligibility Assessment and has an unmet HRSN as indicated by the AHC HRSN Screening Tool, 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 5-4 but who still have unmet HRSNs may receive Navigation to existing federal, state, and local services. If a Member has Medicaid Managed Care, the Social Care Navigator can provide hands-on support and assist with the application for WIC, SNAP, TANF or other existing programs / services.

      Medicaid Managed Care Members who are eligible for Enhanced HRSN Services may opt to be navigated to existing federal, state, and local services instead of Enhanced HRSN Services.

      Some Medicaid Members are not eligible for Screening, Navigation or Enhanced HRSN Services. 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

- Members who are permanently placed in Nursing Home
- Individuals residing in a state Office of Mental Health facility
- Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center
- Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention (CDC) breast, cervical, colorectal and/or prostate early detection program and need treatment for breast, cervical, colorectal or prostate cancer and who are not otherwise covered under creditable health coverage

Table 5-4: Populations eligible for Navigation and Enhanced HRSN Services

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 and have an identified unmet HRSN. Enhanced HRSN Services criteria (additional details follow in HRSN Services Section): i. *Medicaid High Utilizer* (defined by Emergency Department or inpatient utilization) 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.* *High-risk children under the age of 18 (including justice-involved youth, foster care youth, and those under kinship care)*

Eligibility timeframe: Enhanced HRSN Services will be delivered by SCN for a pre-determined duration period. Most Enhanced HRSN Services will be delivered for up to 6 months and may be used in increments. 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*). Navigators may consider the Member's upcoming renewal / prospective disenrollment date in making determinations related to Enhanced HRSN Service delivery. For recurring services (e.g., services that require more than a one-time delivery), the Navigator MAY (at the discretion of the SCN) refer the Member for Enhanced HRSN service delivery only up until the renewal date / prospective disenrollment date, whichever comes first. SCNs will need to establish workflows for Navigators to re-authorize services as appropriate based on Member renewal / reenrollment.

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

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 as part of the first step of the Eligibility Assessment. If a Member is screened for unmet HRSNs using a platform other than the SCN IT Platform, Members will still need to provide consent for the sharing of Screening data (Screening Question 0) as part of the Screening in order for the SHIN-NY to share the screening data with the SCN Lead Entity to proceed with the Eligibility Assessment.

Figure 5-2: Eligibility Assessment activities

Eligibility Assessment *(All Medicaid populations)*				
Step		**Activity***	**Details**	**Data reference**
1		**Collect Member consent and attestation to complete and accurate information**	Ask the Member for verbal consent to conduct Eligibility Assessment and verbal attestation that information provided during the Eligibility Assessment is complete and accurate to the best of their knowledge. Document both consent and attestation in the SCN IT Platform.	• Questions built into SCN IT Platform
2		**Confirm Member identity and Medicaid enrollment**	Check Member Medicaid enrollment via either MEVS or ePACES	• MEVS or EPACES
3		**Confirm HRSN**	Check the SCN IT Platform for HRSN Screening results and confirm with Member	• AHC HRSN Screening results
4		**Confirm desire for services**	Inquire if the Member would like to receive services for unmet needs either via existing services or Enhanced HRSN Services	• Member input
5		**Check Enhanced Population**	Check if Member is part of an Enhanced Population in the Enhanced Services Member File	• Enhanced Services Member File • Member input
6		**Conduct follow-up questions with Member**	For each unmet HRSN, ask additional follow-up questions, including whether they are receiving existing services	• Questions built into SCN IT Platform
If Member is part of an Enhanced Population, complete steps 7-9.	**7**	**Confirm eligibility for Enhanced HRSN Services**	Check Member eligibility against Social Risk Factors and clinical criteria for particular Enhanced HRSN Services using Enhanced Services Member File	• Enhanced Services Member File • Member input
	8	**Confirm desire for services**	Inquire if Member would like to receive Enhanced HRSN Services for which they are eligible	• Member input
	9	**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. Collect Member consent and attestation to complete and accurate information. Member consent must be documented in the SCN IT Platform:

- The Navigator must ask for the Member's consent to conduct Eligibility Assessment using language below:

  I would like to see, based on your medical history including information Medicaid collects, if you qualify for any services that could be helpful and which would be free to you. Is this okay with you? Do you have any questions?

- Finally, the Navigator must ask for the Member's verbal attestation that information provided during the Eligibility Assessment will be complete and accurate to the best of the Member's knowledge.

2. *Confirm the Member's identity and their Medicaid enrollment*:

   To verify a Member's identity, Navigator should match information provided by the Member (e.g., name, address, Medicaid ID number) with data in Medicaid enrollment verification system (e.g., MEVS, ePACES, MEF, etc.).

   For delivery of some Enhanced HRSN services (e.g., home modifications), SCNs may seek to re-verify Member identity at the point of service. OHIP will provide additional guidance after launch.

Social Care Navigator must confirm Medicaid enrollment status for both Fee-For-Service and Managed Care Members using the following pathway:

- Navigators should first check Member profile in SCN IT platform and confirm enrollment using MEVS

- If *Navigator is unable to access MEVS through SCN IT platform*, then Navigator may submit request for eligibility verification by
  (1) checking ePACES and reviewing enrollment details OR
  (2) calling eMedNY's telephone verification service to confirm enrollment
  see *additional guidance for ePACES/eMedNY methods here*.

  Navigators may not have access to eMedNY / ePACES, therefore SCN LEs may establish a workflow whereby LEs can check these sources and provide information to Navigators in order to confirm MMC enrollment

- *If unable to check MEVS / ePACES or use eMedNY telephone verification*, the Navigator should rely on enrollment information displayed in the Member profile in SCN IT platform based on the latest weekly MEF file

  NOTE: MEF enrollment status will have one week lag due to time required to update data

If Navigators are using ePACES or eMedNY's telephone verification services to confirm MMC enrollment, Navigators should refer to the following table to understand if a Member is part of a NYHER – excluded population and therefore is not eligible for screening, navigation, or Enhanced HRSN Services.

Table 5-5: Excluded Population verification guidance

Excluded Population from NYHER (Navigator should not screen or proceed with eligibility assessment)	**Relevant Medicaid code**	**Relevant response via telephonic verification**
Members with provisional eligibility for Medicaid benefits	Coverage code 06	"No coverage, excess income"
Members participating in the Medicare Savings Program	Coverage code 09	"Medicare coinsurance and deductible only"
Members exclusively in the Family Planning Benefit Programs	Coverage code 18, 27	"Eligible Only Family Planning Services", "Eligible Only Family Planning Services No Transportation"
Members residing in a state psychiatric facility	Coverage code 25	"Eligible inpatient services only"
Members who are currently incarcerated	Coverage code 26	"Eligible inpatient services only"
Members who are eligible for emergency services only	Coverage code 07	"Emergency services only"
PACE	Plan type code	If a Member is enrolled in Managed Care, their Managed Care Plan name, address, telephone number will be communicated on the response. This can be used to contact for confirmation of member's LOB.

FIDA IDD	Plan type code	If a Member is enrolled in Managed Care, their Managed Care Plan name, address, telephone number will be communicated on the response. This can be used to contact for confirmation of member's LOB.
Individuals with a "county of fiscal responsibility" code of 97, except for individuals in the New York Office of Mental Health family care program who other than their residence in district 97 would be eligible to enroll in MMMC	Fiscal county code = 97	Client county code 97
Individuals with a "county of fiscal responsibility" code of 98 including Individuals in an Office for People with Developmental Disabilities (OPWDD) facility or treatment center	Fiscal county code = 98	Client county code 98
Individuals who are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast, cervical, colorectal or prostate cancer, and who are not otherwise covered under creditable health coverage (Individuals with a "county of responsibility" code of 99)	Fiscal county code = 99	Client county code 99
Members permanently placed in a nursing home	RRE Codes N1 through N9	Not available (unlikely these members will ever be encountered)

If needed, Navigators may also confirm Member demographic and physical disability questions during this step

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

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

See Screening section above for information on specific questions.

3. *Confirm understanding of the Member's HRSNs*: Check the SCN IT Platform for the Member's HRSN screening results and review any unmet needs with the Member. Identified unmet HRSNs will be mapped to ICD 10 Z codes and SNOMED-CT codes by the SCN IT Platform (*see Eligibility Assessment Coding)*

4. *Confirm that the Member wants to receive help with unmet HRSNs*: Ask if the Member would like to receive services for unmet HRSNs. If they do not, end the assessment here.

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

   As part of this process, the 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 instances in which the information from the interaction between the Navigator and the Member *supersedes* information found in the Enhanced Services Member File (e.g., if relevant criteria are those to which providers / Members may attest). For more information see, *Criteria documentation and attestation*.

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

   Navigators should take the following steps to confirm if a Member is included in an Enhanced population (also applicable for determining clinical criteria and social risk factors for Member eligibility for Enhanced HRSN services):

   i. Navigators should first check the ESMF for enhanced population and clinical criteria

   If criteria has "Y" in ESMF, then Member is considered part of enhanced population or meets the clinical criteria

   If criteria has "N" or "U" in ESMF, there may not be enough information to determine Member eligibility – Navigators should proceed to follow additional steps for verification (see below)
   If EPop_Other field is "N" or "U" and I/DD criteria is relevant for eligibility assessment, Navigator should reference OPWDD Waiver service duplication field in ESMF data if available

   ii. *If Health Homes field is a "U" or "N"* in the ESMF, and field is relevant for eligibility assessment, Navigators can use ePACES to determine HH enrollment (if ePACES is accessible)

   iii. Navigator should then ask the Member whether any criteria with a "U" or "N" could be relevant to the Member OR whether any criteria not included in the ESMF are relevant to the Member

If the Member responds with a yes, Navigator should refer to verification pathways outlined in Table 5-15 for relevant criteria

Navigator should then proceed with provider / member attestation pathways as applicable

In order to streamline the Member interaction, Navigators do not need to ask Member about all criteria with a "U" or "N". Navigators only need to ask Members to verify criteria relevant for services that a Member may receive based on their HRSN screening. Navigators may reference the table below to help inform which criteria may be relevant to review with the Member.

Table 5-6: Navigator guidance: mapping of HRSN domain to relevant ESMF sections

HRSN Domain	ESMF section	Field name	Values indicating Navigator should review criteria with Member
Nutrition	3: Enhanced population	All fields	N, U
	4: Clinical Criteria	Chronic_Condition	N, U
	5: Service Duplication	MTM_ILOS, Nutrition_Counsel, NHTD_Waiver	N, U
Housing	2: Plan Information	Mbr_LOB_Desc	MAP, MLTCP
	3: Enhanced population	All fields	N, U
	4: Clinical Criteria	All fields	N, U
	5: Service Duplication	Healthy_Homes, OPWDD_Waiver, Childrens_Waiver, NHTD_Waiver, TBI_Waiver	N, U
Transportation	3: Enhanced population	All fields	N, U
Care Management	3: Enhanced Population	All fields	N, U
	5: Service Duplication	OPWDD_Waiver, TBI_Waiver, NHTD_Waiver, Childrens_Waiver	N, U

6) *Ask Member follow-up questions to better understand their unmet HRSNs and document answers in Member's Social Care Plan:* Follow-up questions built into SCN IT Platform and the Member's corresponding answers must be documented in the Member's Social Care Plan. The questions are intended for the Navigator and entities that receive referrals 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 follow-up questions that may be asked of Members based on HRSN needs. All relevant questions should ideally be answered Yes / No as part of a comprehensive Eligibility Assessment. However, the Member may decline to answer any particular question within the Eligibility Assessment.

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)?

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?

Additional considerations for <u>Nutrition</u> Enhanced HRSN Services: When navigating Members to Enhanced HRSN Services, Navigators should determine the type of nutrition services that are appropriate for each Member based on their unique needs and eligibility criteria.
During the Eligibility Assessment, for Members who are eligible for BOTH prepared meals (3.2 MTMs or clinically appropriate meals) and groceries (3.3 food prescriptions, food vouchers, or 3.4 pantry stocking), Navigators are encouraged to ask Members the following questions to determine the most appropriate service for the Member.

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

- If Member answers "No" → Refer to MTM or Clinically appropriate meals (based on eligibility criteria)
- If Member answers "Yes" → Continue to question 2

2. Would you or a caregiver be able to prepare and serve adequate, nutritious meals if supplied with ingredients and instructions? If Member answers "No" → Refer to MTM or Clinically appropriate meals (based on eligibility criteria)

- If Member answers "Yes" → Refer to food prescription, food vouchers, or pantry stocking (based on eligibility criteria)

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

7) *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.

- *Healthy Homes Pilot Considerations:*

A "Y" indicator for the Healthy_Homes field on the ESMF flags to the Navigator that the Member's household consented to participate in the pilot and completed at least an initial asthma and/or dwelling visit under the Healthy Homes Pilot. Further discussion with the Member is required to understand the extent of Pilot home improvement services delivered to the household and to determine whether additional supports under Asthma Remediation are warranted.

If a Member has a "Y" indicator on the ESMF for this data field and the Navigator needs to learn more, the Navigator should ask the Member: *Did your household receive home improvement services under the NYS Healthy Homes Pilot from a NYSERDA-participating contractor?* If the Member answers yes, the Navigator should ask for additional details regarding the type/extent of home improvement services received and consider these in the context of appropriate Enhanced HRSN services from the SCN Program.

8. *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.

9. *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. A Member's eligibility for enhanced HRSN services 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. Screening and Eligibility Assessments should occur on an individual basis (i.e., each individual within a household should receive a separate Screening and Eligibility Assessment).

Navigators should ask Members if other individuals in their household are eligible for or receiving Enhanced HRSN services. Other individuals in the household may impact how certain services are delivered—see Table 5-7 for additional details.

OHIP will provide additional workflow details for Navigators in future guidance.

Table 5-7: Household guidance for Navigators

Service category	Services	Potential OHIP guidance (fee schedule v2)
Housing	**2.1 Home Accessibility and Safety Modifications**	Social Care Navigators will authorize services that are required to address the HRSNs of the individual Member, which may include both individual spaces (e.g., Member's bedroom) and shared spaces within the home. OHIP will be monitoring distribution of spending across these services.
	2.2a Home Remediation Service: Mold and Pest Remediation	
	2.2b Home Remediation Service: Ventilation Improving Systems	

	2.2c Home Remediation: Equipment Provision	
	2.3b Asthma Remediation and Supportive Products	
	2.6a Utility Setup - Activation Expenses	Coverage for phones is intended to be for landlines. In the event that a Member uses a cellular phone in place of a landline, cellular phones are limited to one phone plan per household, even if the household includes multiple Members. Minors under the age of 18 years are not eligible for cell phone coverage. For Members who are enrolled in a cellular phone 'family plan', utility services will cover the equivalent of one cellular phone line.
	2.6b Utility Setup – Back payment	
	2.6c Utility Assistance	
	2.8a Community Transitional Supports (CTS)	CTS services will be provided at the household level (i.e. one unit of service per household), as CTS components (e.g., rent, security deposit, pantry stocking) have been estimated based on unit size. As part of the Enhanced HRSN Care Management process, the Social Care Navigator will determine whether other individuals in a Member's household are already receiving CTS services through the SCN program and avoid providing duplicative services across Members sharing a household.
Nutrition	**3.2a Medically Tailored Meals and 3.2b Clinically Appropriate Home Delivered Meals**	As part of the Enhanced HRSN Care Management process, the Social Care Navigator will determine the number of eligible Members in a household and facilitate efficient service delivery (e.g. ensure meals for Members sharing a household come from the same HRSN service provider, streamline delivery costs by ensuring meals for the same household are delivered in a single trip, etc.)
	3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	OHIP has set household-level ranges based on the number of Members in a household who are eligible for Medically Tailored or Nutritionally Appropriate Food Prescriptions. As part of the Enhanced HRSN Care Management process, the Social Care Navigator will determine how many Members in a household will receive 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions.
	3.4 Fresh Produce and Non-perishable Groceries (Pantry Stocking)	OHIP has set household-level ranges based on the number of Members in a household who are eligible for 3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking). As part of the Enhanced HRSN Care Management process, the Social Care Navigator will determine how many Members in a household will receive 3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)

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

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

MMC Members who have been released from incarceration within the last 90 days and have a chronic condition (including but not limited to substance use disorder, SMI, and hepatitis C) and high-risk justice-involved youth (under the age of 18) with an identified unmet health-related social need may be eligible to receive Enhanced HRSN Services through the SCN program (see Covered Population section for additional detail on eligibility criteria). SCNs are expected to conduct proactive outreach and support eligible individuals within these populations to receive HRSN services.

Per the Social Security Act, Medicaid is typically suspended during incarceration and then reactivated up to 30 days prior to release. Members are initially reactivated into Medicaid Fee-for-Service (FFS) and then enroll in Medicaid Managed Care 30 to 120 days after release from an incarceration facility. The timing of Medicaid reactivation may depend on whether the Member is in a federal or state prison, a juvenile detention center, or a county jail.

Considerations for Criminal Justice-Involved Adults:

Adult MMC Members who are up to 90-days post release from incarceration and who have a diagnosis of a chronic condition (including but not limited to substance use disorder, SMI, and hepatitis C) and an unmet health-related social need are eligible for Enhanced HRSN services. OHIP envisions that these individuals will:

- Receive HRSN screening in a timely manner upon release so that they can be navigated to appropriate social care services based on eligibility, and
- Re-enroll in MMC once eligible in order to be able to receive Enhanced HRSN Services as appropriate during the 90-day window

OHIP encourages SCN Lead Entities to partner with jails and prisons in their region to support Members to receive HRSN screening upon release. Jails and prisons do not need to be included in the Network (i.e., contracted with the SCN Lead Entity).

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

- SCN Lead Entities may work with ecosystem partners to ensure that individuals are referred to the SCN for screening in a timely manner following release (e.g., establishing relationships with discharge planners and/or case managers in order to ensure continuity of support for individuals)
- SCN Social Care Navigators may assist Members in the transition from FFS to MMC by providing contact information for individuals trained in Medicaid enrollment (e.g., MCO enrollment

counselors, NY Enrollment Counselors). Navigators are not expected to support Members to fill out enrollment paperwork and forms

- SCN Lead Entities may include in their Networks HRSN service providers that specifically serve criminal justice populations and engage with individuals immediately after release in order to help them transition to MMC and also receive screening

Considerations for Justice-Involved Youth:

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

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

Section 5121 of the federal government's 2023 Consolidated Appropriations Act requires States to provide certain services under Medicaid and CHIP for juvenile-justice involved youth (those under 21 years of age and former foster youth up to age 26 who became incarcerated while enrolled in Medicaid or re determined eligible for Medicaid while incarcerated). By January 1, 2025, OHIP will establish a plan to provide:

- In the 30 days prior to release, screenings and diagnostic services in accordance with the Early Periodic Screening Diagnostic and Treatment (EPSDT) requirements, including behavioral health screenings or diagnostic services, as well as case management 30 days pre- and post release
- In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services in the geographic region of the home or residence of the eligible juvenile
- SCNs will be expected to work with providers of case management services to support screening and Social Care Navigation for justice-involved youth. OHIP will provide additional guidance to SCN Lead Entities as the NYS plan is finalized.

v. 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 identifying unmet HRSNs in the Screening, 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 (ESMF) Overview

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

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

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

Process by which the ESMF will be created:

OHIP will provide a state-prescribed ESMF Template to the MCOs. MCOs will then use the ESMF Template to:

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

Timing for sharing the ESMF:

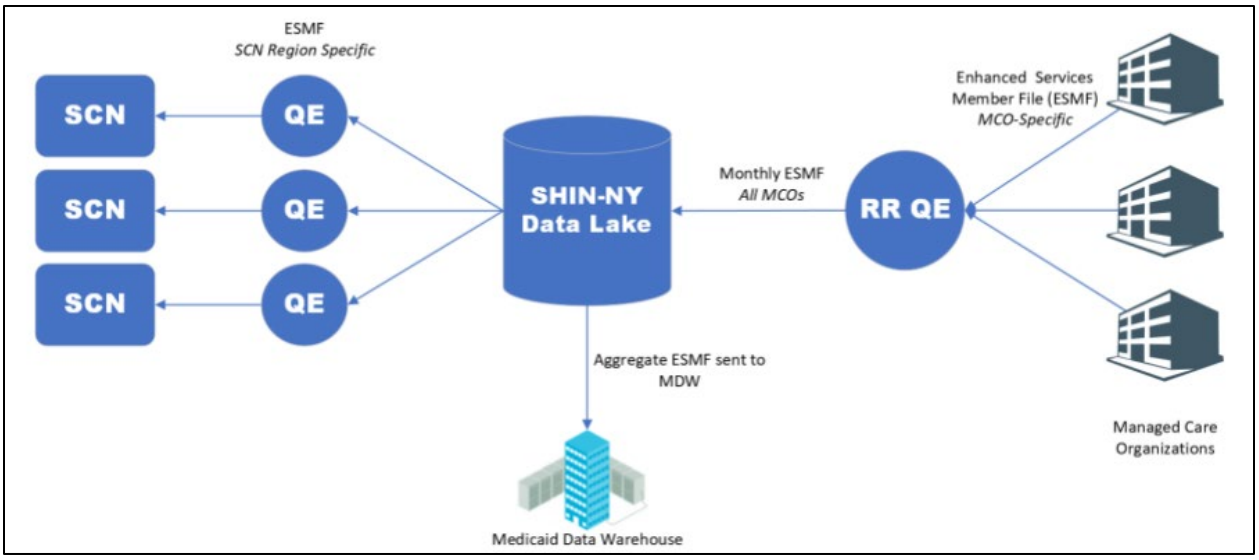
On the 28th of each month, each MCO will transfer their ESMF file to the RRHIO. MCOs will work with the RRHIO to remediate data quality issues by the 4th of the following month. On the 5th of each month, the QEs transfer regional ESMF to each SCN.

Process by which the ESMF will be shared:

Once NYeC/SHIN-NY receives the ESMF from MCOs:

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

Figure 5-3: Process for sharing of Enhanced Services Member File (ESMF)



Process by which SCNs communicate to MCOs regarding new Member information:

During the Eligibility Assessment, SCNs may learn new Member information that may be relevant to MCOs (i.e., through Provider attestation or Member documentation). SCN Lead Entities and MCOs will need to work together to establish a process by which SCN Lead Entities communicate this new Member information to MCOs.

OHIP will not require MCOs to update their ESMF data with information shared by the SCN Lead Entity. *Please see the Data & Systems Implementation Guide (DSIG) for more information.*

iii. Information included in the ESMF

The ESMF must include all Members enrolled in a MCO regardless of Enhanced Population status.

Data elements of the ESMF 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 date of birth

        - Member's address (MCOs will use the residential address on the Member's 834 file when populating the ESMF file.)
        - 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
- MCO Renewal Date / Prospective Disenrollment Date
    - The enrollment date can provide a general baseline for the Navigator to understand how much historical data the MCO may have on a Member
    - If the MCO is aware of a prospective disenrollment date or renewal anniversary date

f. CHANGES IN MEMBER MEDICAID COVERAGE

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

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

i. Change in Member MMC coverage

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

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

1. **Guidance regarding Members with upcoming potential changes in MMC (e.g., potential upcoming disenrollment from MMC)**

   Member Medicaid coverage is typically re-verified annually. OHIP recognizes that some Members will therefore have to re-verify MMC coverage while receiving Enhanced HRSN Services. SCN Lead Entities should ensure that Navigators will:

   - **Check MEVS for the latest information during the Eligibility Assessment**: When creating a Social Care Plan, Navigators should consider the Member's upcoming renewal and prospective disenrollment date. For recurring services, the Navigator MAY (at the discretion of the SCN) refer the Member for Enhanced HRSN service delivery only up until the renewal date / prospective disenrollment date, or the maximum service duration end date, whichever comes first.
   - **Consider a Member's upcoming renewal date:** When authorizing Enhanced HRSN services, Navigators should consider the Member's upcoming MMC renewal date / prospective disenrollment date. Navigators should make an effort to ensure services are delivered only to Members that are enrolled in MMC with expected MMC enrollment through at least expected completion of Enhanced HRSN services (e.g., home modifications/asthma remediation).

- **Direct Members to existing re-enrollment programs and resources to enable MMC re-enrollment (e.g., Certified Application Counselors, Marketplace Facilitated Enrollers and Navigators) if the individual has coverage through NY State of Health:** Social Care Navigators and Members can find the list of the over 5,550 statewide application assistors on the NY State of Health Website, which enables filtering of assistors by specific areas. For aged, blind and disabled individuals whose eligibility is determined by a local Department of Social Services, a Facilitated Enroller for the Aged, Blind and Disabled can assist in the application process. Additionally, OHIP plans to provide additional information regarding non-NY State of Health assistors

- **SCN Navigators are not required to directly support Members with MMC or FFS re-enrollment** (e.g., completing forms)

2. Guidance regarding Members who have experienced a change in MMC coverage

OHIP expects that most Members will be able to re-verify MMC plan coverage. In the case of a change in Member eligibility (e.g., Member is disenrolled from a MMC plan), SCNs should establish processes consistent with the following OHIP guidance:

- **Verification of Member Eligibility in MEVS**: SCNs will be expected to verify Member coverage in MEVS. SCN IT Platforms will be integrated with the Medicaid Eligibility Verification System (MEVS) in order to verify Medicaid enrollment using one of the MEVS methods
    - *OHIP will provide additional information regarding expectations for the frequency of MMC and FFS coverage verification over the course of Enhanced HRSN Service delivery in forthcoming guidance*

- **SCN communication expectations:** SCNs are expected to create a process to quickly inform their Network HRSN service providers of changes in coverage of a Member receiving Enhanced HRSN Services

- **Delivery of Enhanced HRSN Services:** The SCN Lead Entity and HRSN service providers are responsible for stopping delivery of services to Members who are no longer covered by a MMC plan and thus are no longer eligible to receive Enhanced HRSN Services
    - **Home modifications / asthma remediation:** if a Member disenrolls from MMC while their home modification or asthma remediation is underway, SCNs must end provision of the home modifications/asthma remediation and return the Member's home to serviceable condition. Services should not be provided while the Member is not enrolled in MMC.

- **Supporting previously enrolled Members:** OHIP acknowledges that Members who experience a change in Medicaid coverage may need support in finding federal, state, or local resources, reenrolling in Medicaid, or communicating with their HRSN service providers:
    - If a Member is disenrolled from MMC and subsequently enrolled in Medicaid FFS, Navigators will be reimbursed for Navigation supporting Members to find existing local, state and federal resources
    - If a Member is disenrolled from Medicaid, a Navigator *cannot* be reimbursed using waiver funds for providing navigation services to the individual. Navigators may at

their discretion connect individuals to other navigation resources not supported by waiver funds to access existing federal, state, and local services

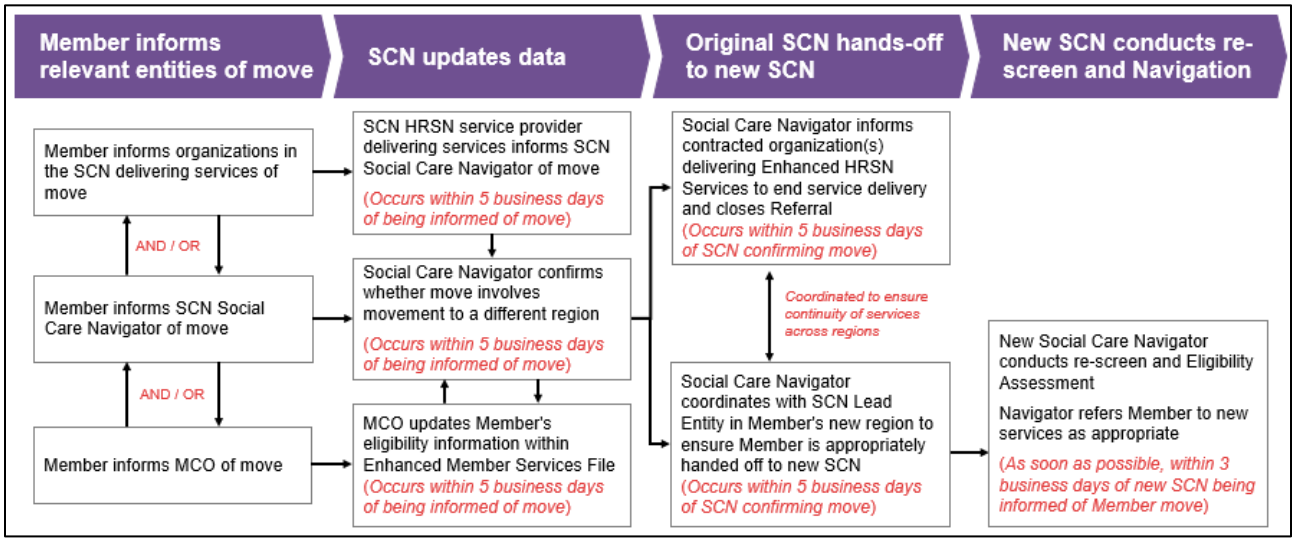
ii. Member movement across SCN regions

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 a new SCN lead Entity.

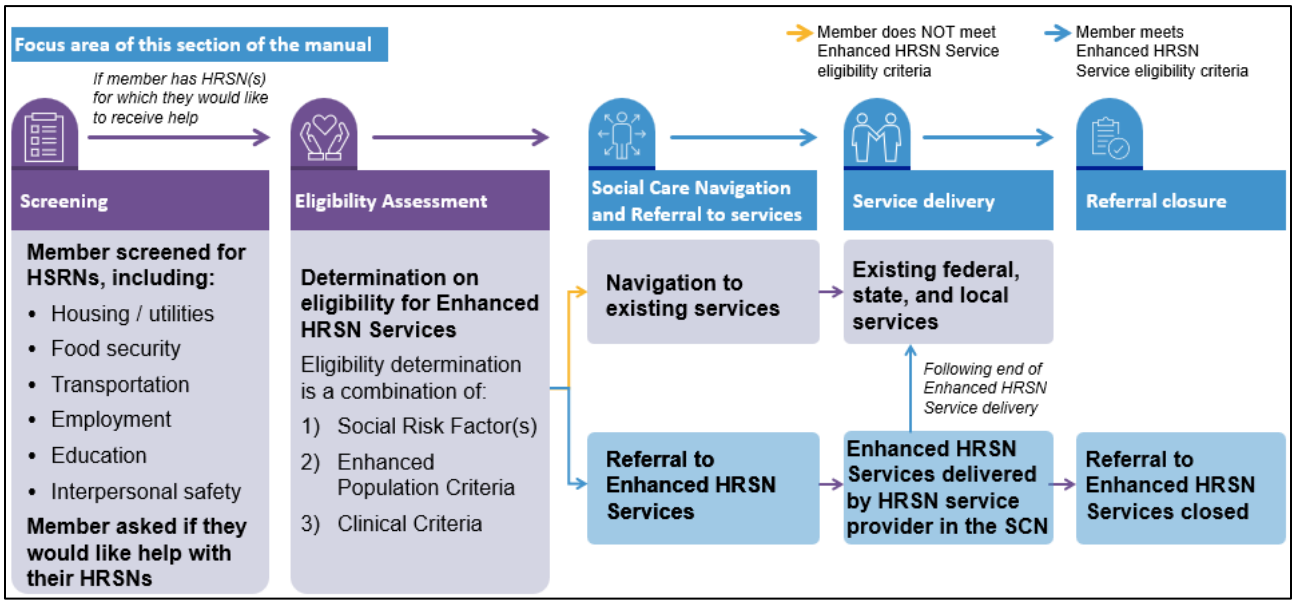
The process for updating the Member's assigned SCN will proceed as follows (*see Figure 5-4*):

- 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 5-4: Process flow for Members that move between SCN regions



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.

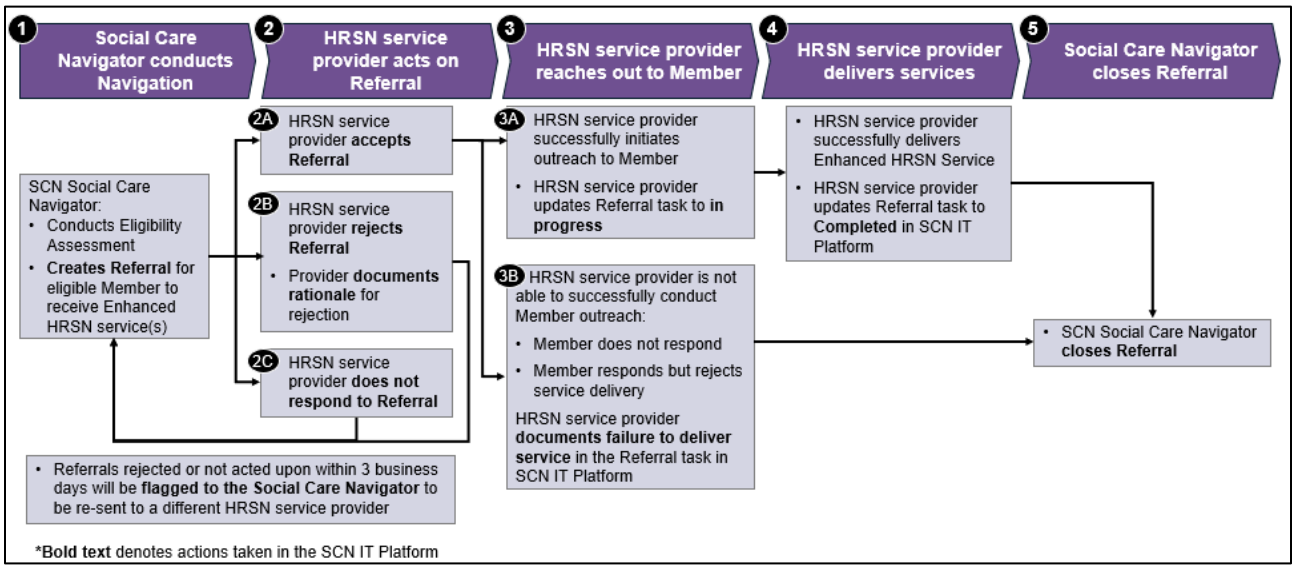
This section outlines:

- **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 5-5: 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 5-8).

Table 5-8: 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. A 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 5-9 for contact timeline expectations per received Enhanced HRSN Service)*. These contact points are intended to:

- Determine if Enhanced HRSN Services are meeting Member needs.
- Support in transitioning the Member to additional supports after the end of Enhanced HRSN Service Delivery (e.g., existing federal programs), where relevant and desired. For example, if a Member is receiving the Nutrition Enhanced HRSN Service of 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 5-9 for contact timeline expectations per received Enhanced HRSN Service)* to:

- Confirm service delivery completion, and
- Support in transitioning the Member to additional supports (e.g., existing federal 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 5-9: Member contact timelines at end of service delivery, per service type

HRSN Category	HRSN Service	Timing of contact before end of service delivery	Timing of contact after end of service delivery
Care Management	1.1 Navigation Services	Not applicable – not an Enhanced HRSN Service	
	1.2 Enhanced HRSN Care Management	N/A	Within 5 business days after service completion
Housing	2.1 Home Accessibility and Safety Modifications	N/A	Within 5 business days after service completion
	2.2 Home Remediation Services	N/A	Within 5 business days after service completion
	2.3 Asthma remediation	HRSN service provider follows up with the Member no earlier than 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-Procedure and Post-Hospitalization	Medical respite provider contacts Member 14 days before service completion	Within 5 business days after service completion
	2.5 Rent / temporary housing for up to six months	Ongoing throughout service delivery to assist in transition to additional supports **AND** 60 days before service completion or as soon as possible for services delivered for <60 days	Within 5 business days after service completion
	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

	3.2a Medically tailored meals	60 days before service completion **AND** 10 days before service completion	Within 5 business days after service completion
	3.2b Clinically appropriate home delivered meals	60 days before service completion **AND** 10 days before service completion	Within 5 business days after service completion
	3.3 Medically tailored or nutritionally appropriate food prescriptions	60 days before service completion **AND** 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).

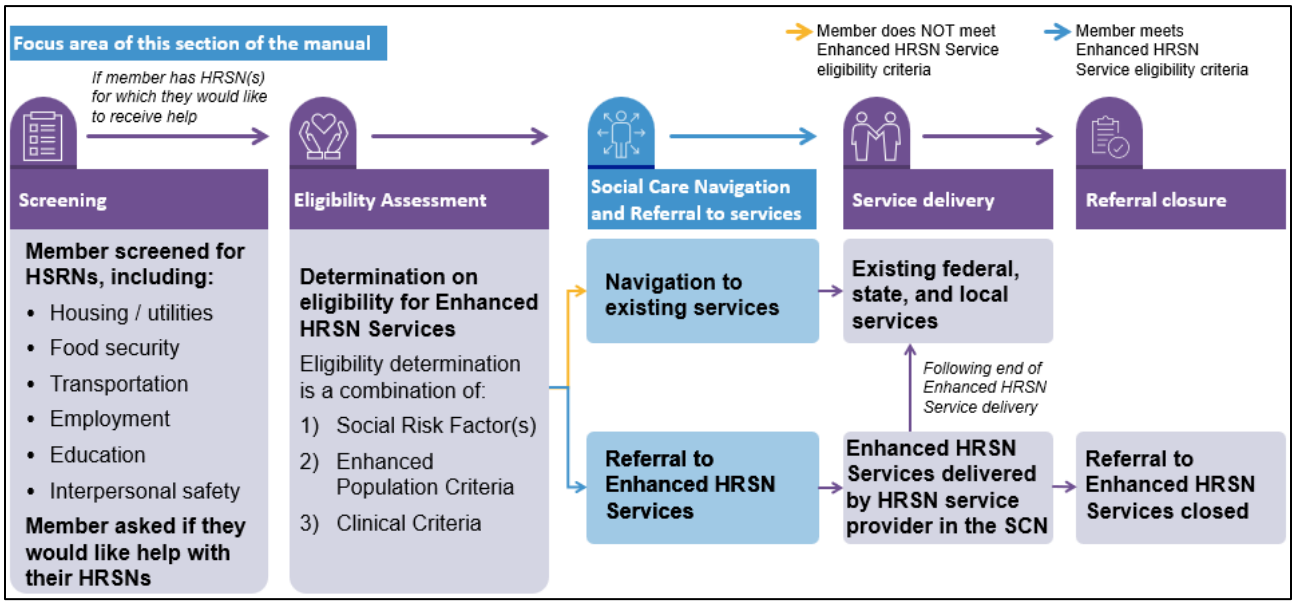
iv. Distribution of Referrals across Network

SCNs should strive to ensure a balanced distribution of Referrals across organizations in the Network. Organizations providing both Navigation and HRSN service delivery are required to follow their SCN's

conflict of interest plan to ensure they operate in the Member's best interests (*see SCN Conflict of Interest Plan*).

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

h. SOCIAL CARE PLANS



i. Social Care Plan overview

Each Member in an Enhanced Services Population will have a Social Care Plan developed by their Navigator while they are engaged with the SCN program. A Member's Social Care Plan will be initiated at the end of the Eligibility Assessment and should be updated by the Navigator as needed throughout the duration of the time the Member engages the SCN program. The Social Care Plan includes details regarding Member assessment and Member's HRSNs in order to inform the services and care they receive. Each Social Care Plan will identify the Member's unique needs, individualized strategies, and interventions for meeting those needs. Social Care Plans will be 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.

Navigator should document in the Social Care Plan all Member information learned during interactions with the Member that is relevant to the SCN program and provision of Enhanced HRSN services. Select examples of details that may be included in the Social Care Plan could include (but are not limited to) are outlined in *Table 5-10* below.

Table 5-10: 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 • Best contact information and guidance for Navigator to be in touch with Member • 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 • Upcoming Member MMC renewal date / prospective disenrollment date, and plan to support Member leading up to their renewal
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.

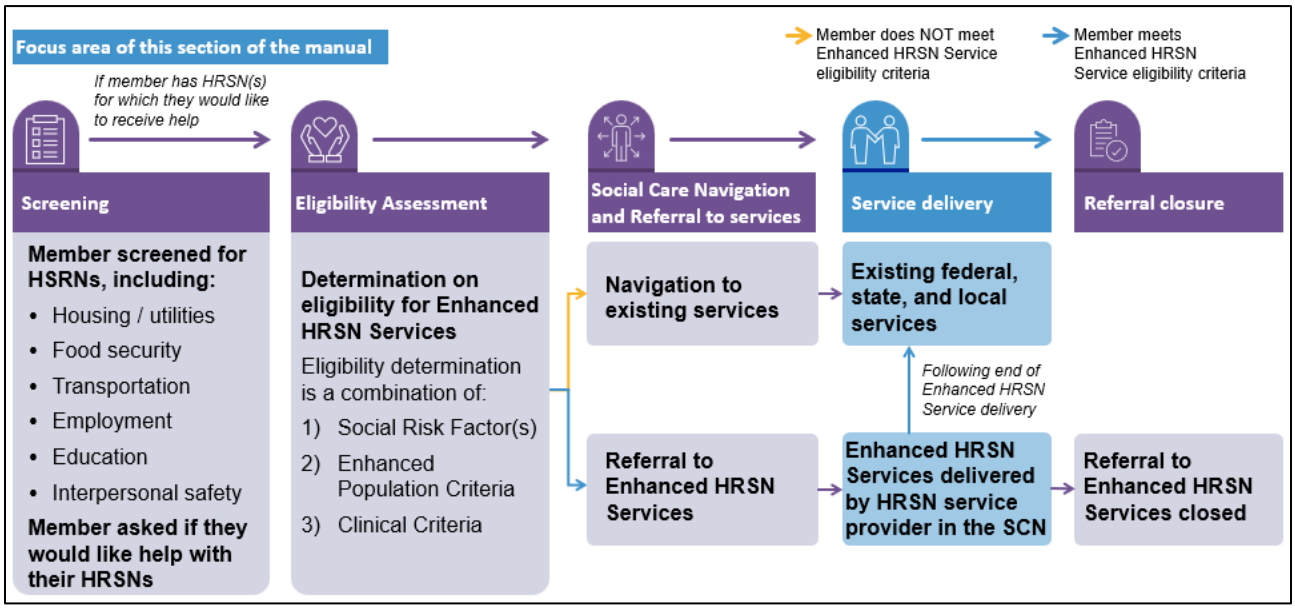
Additional details to include in Social Care Plans for children and youth

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 may be reimbursed for up to six months. Medically tailored meals and clinically appropriate meals are able to be reimbursed for an additional six months if the SCN determines that the individual still meets the clinical and needs-based criteria. Select Nutrition services may be reimbursed for up to 11 months for high-risk pregnancies, and not to exceed twelve months postpartum. Other services are limited as noted below.

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

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 5-11: 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 **have an identified 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. In the event that eligibility criteria for Enhanced HRSN Services change over the course of this program, Members already receiving services will not have their services interrupted. The Member does not need to be reassessed to meet new criteria in order to receive services. However, once service delivery is complete (e.g., at the end of 6 months), the Member must meet the new eligibility criteria, as determined in an additional eligibility assessment, in order to receive additional services.

ii. 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 https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm 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 5-12: Enhanced Population Description

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 • Admission or discharge from an Acute Care hospitalization related to a health condition or illness, as a qualifying condition for Medical Respite Service Only
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 12 months postpartum.

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[1], including substance use disorder and hepatitis C.
High Risk Children under the Age of 18 (including justice involved youth, foster care youth, and those under kinship care)	Members under 18 who have at least one of the following: • A chronic condition, (e.g., mental health condition, developmental delay, chronic life-threatening allergies, physical disability, and asthma); • Overweight, obese, or underweight as a qualifying condition for nutrition interventions only; • Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition as a qualifying condition for nutrition interventions only; • Child maltreatment as defined by the CDC; • Is a child with a special healthcare need (CYSHCN) as defined by HRSA; • Low birth weight of <2500 grams; • or • A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect

[1] 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 identified unmet HRSN from Member's screening results, the Social Care Navigator must assess the related Social Risk Factor (*Table 5-13*).

Table 5-13: Social Risk Factors

AHC HRSN Screening Tool Question and Related Unmet Need Response	Risk factor	Risk Factor Description
Housing: *What is your living situation today?* • I have a place to live today, but I am worried about losing it in the future • I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	Housing related need	An individual who: Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5), except for the annual income requirement in 24 CFR 91.5 (1)(i)). Transitioned out of institutional care / congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals within the past 90 days or Youth transitioning out of the child welfare system including foster care. 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, except for the annual income requirement in 24 CFR 91.5 (1)(i)). Transitioned out of institutional care / congregate settings such as nursing facilities, large group homes, congregate residential settings, IMDs, correctional facilities, State Psychiatric, State or Voluntary Community Residence, Single Room Occupancy (SRO), and acute care hospitals within the past 90 days or Youth transitioning out of the child welfare system including foster care.
Nutrition: *Within the past 12 months, you worried that your food would run out before you got money to buy more.* • Often true • Sometimes true	Nutrition related need	An individual who screens often true or sometimes true to the nutrition questions on the AHC HRSN Screening Tool and meets the USDA definition of low food security in which the individual reports reduced quality, variety, or desirability of diet; little or no indication of reduced food intake; or very low food security in which the person reports multiple indications of disrupted eating patterns and reduced food intake.
Nutrition: *Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.* • Often true • Sometimes true	Nutrition related need	An individual who screens often true or sometimes true to the nutrition questions on the AHC HRSN Screening Tool and meets the USDA definition of low food security in which the individual reports reduced quality, variety, or desirability of diet; little or no indication of reduced food intake; or very low food security in which the person reports multiple indications of

		disrupted eating patterns and reduced food intake.
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. Eligible Population, Social Risk Factors, and Clinical Criteria by service

Appropriate Enhanced HRSN Services for the Enhanced Population with identified social risk factors will be determined using clinical criteria *(Table 5-14)*.

Table 5-14: Eligible Population, Social Risk Factors, and Clinical Criteria by Service

Service	Eligible Population	Social Risk Factor	Clinical Criteria
1) Care Management			
1.1 Navigation	All Medicaid Members with identified unmet HRSN	Enrolled in Medicaid and screens as having an unmet need using the AHC HRSN Screening Tool	N/A
1.2 Enhanced HRSN Care Management	All Enhanced Populations	Enrolled in Medicaid Managed Care and screens as having an unmet need using the AHC HRSN Screening Tool	Enhanced Population.
2) Housing			
2.1 Medically necessary home accessibility and safety modifications: Ramps, handrails, grab bars pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities domain 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 • Documentation from Member's provider attesting to medical necessity
2.2a Medically necessary home remediation services: mold / pest remediation	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities domain Requires a clinically appropriate home	• Has a health condition or is at risk for a health condition that is exacerbated by the individual's physical living environment; and • Documentation from Member's provider attesting to medical necessity

Service	Eligible Population	Social Risk Factor	Clinical Criteria
		modification/remediation service.	
2.2b Medically necessary home remediation services: repairing or improving ventilation systems including air conditioners, heaters, humidifiers, dehumidifier	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities domain 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.	• Chronic condition (such as, diabetes, congestive heart failure (CHF), chronic kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS) • Previous heat-related illness (heat stroke, heat exhaustion, heat syncope, Rhabdomyolysis, heat cramps, or heat rash) requiring emergency room or urgent care visit, within the last 12 months that occurred at home. • Previous cold-related illness (hypothermia, frostbite, trench foot, or chilblains) requiring emergency room or urgent care visit within last 12 months that occurred at home. • Individuals regularly taking medications or have an otherwise stated condition that interferes with daily thermoregulationHigh-risk youth (as defined in enhanced population) who are under the age of 6 • Pregnant and Postpartum Persons • Individuals with Intellectual and Developmental Disabilities • Individuals with Substance Use Disorder • Individuals with Serious Mental Illness
2.2c Medically necessary home remediation services, refrigeration units as needed for medical treatment	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities and/or food insecurity domain Resides in their own home or non-institutional primary residence and for whom an air conditioner, heater, air filtration device, and/or refrigeration unit for medications or breast milk is clinically appropriate as a component of health services treatment or prevention.	• Prescribed medication requiring refrigeration for the management of a chronic condition • Pregnant and postpartum persons that require refrigeration for breast milk • Enteral and parenteral nutrition
2.3 Asthma Remediation	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities domain Requires a clinically appropriate home	• 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

Service	Eligible Population	Social Risk Factor	Clinical Criteria
		modification/remediation service. Has a health condition that is exacerbated by the individuals physical living environment.	• 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	All Enhanced Populations	An individual who 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, except for the annual income requirement in 24 CFR 91.5 (1)(i).	Service is restricted to individuals that are: • 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, 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 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, 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 • Individuals who are homeless as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).; or • Youth transitioning out of the child welfare system including foster care
2.6 Utility Setup / Assistance	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities 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 • Individuals who are homeless as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).; or • Youth transitioning out of the child welfare system including foster care
2.7 Pre-tenancy services	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under housing / utilities domain; and	Enhanced Population.

Service	Eligible Population	Social Risk Factor	Clinical Criteria
		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).	
2.8 Community Transitional Services	All Enhanced Populations	An individual who 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, except for the annual income requirement in 24 CFR 91.5 (1)(i).	Enhanced Population.
2.9 Tenancy sustaining services	All Enhanced Populations	An individual who 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, except for the annual income requirement in 24 CFR 91.5 (1)(i).	Enhanced Population.
2.10 Housing Transition and Navigation Services	All Enhanced Populations	An individual who 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, except for the annual income requirement in 24 CFR 91.5 (1)(i).	Enhanced Population.

Service	Eligible Population	Social Risk Factor	Clinical Criteria
3) Nutrition			
3.1 Nutritional Counseling and Education	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under food security domain, and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC screening tool	Enhanced Population.
3.2a Medically Tailored meals	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under food security domain, and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC screening tool	• 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), or • Pregnant and postpartum persons
3.2b Clinically Appropriate Home Delivered Meals	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under food security domain, and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC screening tool	Enhanced Population.
3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under food security domain, and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC screening tool	Enhanced Population.
3.5 Fresh Produce and Non-Perishable	All Enhanced Populations	An individual who is assessed to have unmet	• Pregnant and postpartum persons, or

Service	Eligible Population	Social Risk Factor	Clinical Criteria
Groceries (Pantry Stocking)		HRSN(s) under food security domain, and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC screening tool	• High-risk children under the age of 18 (including justice- involved youth, foster care youth, and those under kinship care)
3.5 Cooking Supplies	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under food security domain, and Meets the USDA definition of low or very low food security as determined by having an unmet HRSN need under food security domain per AHC screening tool	Enhanced Population.
4) Transportation Services			
Transportation related to HRSN service or care management	All Enhanced Populations	An individual who is assessed to have unmet HRSN(s) under transportation 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.	Enhanced Population.

v. Criteria documentation and attestation

A key required step of the Eligibility Assessment is the Social Care Navigator confirming the Member's eligibility for Enhanced HRSN Services. Most criteria related to eligibility (both the enhanced population criteria and clinical criteria associated with specific Enhanced HRSN Services) will be shared with SCNs through the Enhanced Services Member File (ESMF) (*see Eligibility Assessment Process and ESMF* for

more details). However, there may be circumstances in which the Navigator must use additional information beyond the ESMF to determine a Member's eligibility for Enhanced HRSN Services.

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

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

OHIP has outlined different sources that may be used to validate each criterion (see details in Table 5-15). OHIP's goal is to maximize Member access to Enhanced HRSN Services by creating multiple pathways for eligibility validation while also ensuring services are provided to eligible Members. Sources for Social Care Navigators to validate Member eligibility to receive Enhanced HRSN Services include the following…

- Data included in the ESMF (i.e., data available from MCO)
- Provider attestation (i.e., OHIP-standardized form signed by providers attesting to Member eligibility on the basis of specific criteria)
- Member attestation (i.e., verbal attestation to specific criteria captured by the Navigator)
- Member documentation (i.e. materials shared by the Member validating specific criteria)

Navigator workflow to collect Provider attestation

A healthcare provider may attest to specific criteria outlined in Table 5-15 below. The process for Provider attestation is intended to minimize burden on the Member, Provider, and Social Care Navigator, while ensuring that Member's eligibility determination for Enhanced HRSN Services is within the appropriate remit of each stakeholder (e.g., the Social Care Navigator will not make clinical decisions, care managers cannot make clinical diagnoses but can review the Member's health records, etc.).

OHIP has created a standard Provider attestation form in order to streamline the attestation process for Providers, Social Care Navigators, and Members. The form will be made available to SCNs prior to service start. If the Social Care Navigator determines that Provider Attestation is needed in order to confirm Member eligibility, the Navigator can request and receive Provider attestation by either (1) the Provider submitting the OHIP standard attestation form directly to the Navigator through HIPAA compliant transmission methods; OR (2) a Member submitting the OHIP standard attestation form on behalf of their Provider to the Navigator.

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

- Discussing with the Member options for outreach to the Provider with form and completion details
- Providing guidance for how the Provider can submit the documentation to the Social Care Navigator through a HIPAA compliant transmission method
- Conducting outreach and follow-up, as needed to the Member and/or Provider to check on the status of the documentation

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

If the Healthcare Provider is attesting to any criteria included in the "Maternal or Child health" section of the provider attestation form (e.g., pregnant or postpartum criteria) and sharing back with the SCN, the SCN must provide to the Healthcare Provider a signed form regarding the disclosure of protected health information. The SCN should sign and provide this form to the Healthcare Provider along with the attestation form.

OHIP will provide SCNs with a document that includes both forms:

- Form for providers to attest to eligibility criteria
- Form for SCNs to attest regarding the disclosure of PHI

Providers who may attest: Providers completing the OHIP-standardized form attesting to Members meeting eligibility criteria must be either:

1. **A NYS licensed health care provider that accepts Medicaid Members. These providers will need to attest that:**
    - They are providing an attestation for enhanced populations or clinical criteria within their scope of authorized practice under state law; OR
    - They have sufficient access to information (e.g., electronic health record) pertaining to the clinical criteria/enhanced population
2. **Other health care providers that are part of programs within larger agencies that accept Medicaid Members (e.g., Health Home, School-based Health Center) and with access to necessary clinical information (e.g., Member's relevant medical records). These providers will need to attest that:**
    - They have reviewed documentation from a licensed Medicaid-enrolled provider per eMedNY and can attest to the Member meeting specified eligibility criteria

If a Health Care Provider at a rehabilitation center completes the provider attestation form, the rehabilitation center may need to coordinate with the Member to obtain any necessary HIPAA release permission / documentation to be able to share the form back with the SCN.

Navigator workflow to collect Member attestation / documentation

Members may attest and/or provide documentation for a subset of criteria outlined in Table 5-15. OHIP's suggested process for collecting Member documentation and attestation is intended to reduce burden on the Member and the Social Care Navigator while ensuring appropriate access to Enhanced HRSN Services.

Member attestation: For criteria for which Member attestation may be used to determine eligibility for Enhanced HRSN services, Navigators will ask Members to provide verbal attestation to the criterion that must be documented by the Navigator in the SCN IT Platform (e.g., via a checkmark confirmation in the SCN IT Platform). When completing Member attestation, Navigators may rely on the following script (outlined below) for criteria relevant to the Member and their potential unmet HRSN.

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

Script for Navigators:

Tell Member: *Please answer the following questions with a "yes" or "no" answer.*

Pregnancy and Postpartum Status:

- Ask Member: *Are you currently pregnant or up to 12 months postpartum?*

If pregnant or postpartum and interested in refrigeration units as part of medically necessary home modifications:

- Ask Member: *Do you require refrigeration for storage of breast milk?*

Physical disability that limits independence: as part of the criterion for medically necessary home modifications

- Ask Member: *Do you currently have a physical disability that limits independence in your home, such as difficulty walking or temporary paralysis?*

Heat or cold-related Illness: for the "at-home" criterion needed for medically necessary home modifications, including medically necessary air conditioners, heaters, humidifiers, dehumidifiers

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

Member documentation: For criteria for which Member documentation is needed to determine eligibility for Enhanced HRSN services, the Social Care Navigator should work with the Member to develop a plan for how the Member will obtain and submit required documentation. The Navigator's support and planning should include:

- Sharing acceptable forms of documentation with the Member

- Detailing guidance for how the Member can submit the documentation to the Social Care Navigator
- Conducting outreach and follow-up, as needed to the Member to check on the status of the documentation

The Navigator is required to store the Member documentation on the SCN IT Platform.

Table 5-15: Eligibility determination pathways for each Enhanced Population and Enhanced HRSN Service

Note on the table below: *Criteria for which Provider and Member attestation and/or documentation may be used are subject to change. OHIP will share further guidance for pathways that noted as "To be determined"*

Category (population or service)	Description of criterion	*How criteria may be validated to determine eligibility*			
		ESMF	**Provider Attestation**	**Member Attestation**	**Member documentation**
Enhanced Population Criteria					
Medicaid High Utilizer (adults and children)	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	No	No
Enrolled in a NYS Health Home (adults and children)	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	No	No
Individuals with Substance Use Disorder (SUD)	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	No	No
Individuals with Serious Mental Illness (SMI)	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	No	No
Individuals with Intellectual and Developmental Disability (adults and children)	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	No	No
Pregnant and Postpartum Persons	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	Yes	No
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	Yes Note: Only some MCOs may be able populate this field	No	No	Yes Acceptable forms of documentation include one document from the list below: • Formal release paperwork (e.g., certificate of discharge) • Email from employee of government agency (e.g., parole, probation officers, case worker, school administrator)
	Members have a chronic condition*, including substance use disorder and hepatitis C.	Yes	Yes	No	No

	**A full list of Eligible Chronic Conditions can be found here: Health Home Chronic Conditions (ny.gov)*				
High-Risk Children under the Age of 18 (including justice- involved youth, foster care youth, and those under kinship care)	See *Covered Populations* for description of Enhanced Population criterion	Yes	Yes	No	No
Clinical Criteria:					
1.1 Navigation services	N/A (All Medicaid Members eligible)	*N/A*			
1.2 Enhanced HRSN Care Management	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
2.1a Medically necessary home modifications: Medically necessary home modifications (Ramps, handrails, grab bars etc.)	Documentation from Member's provider attesting to medical necessity	No	Yes; **Required**	No	No
	Physical disability that limits independence	No	No	Yes; **Required**	No
2.2a Medically necessary home remediation services: mold / pest remediation.	Has a health condition or is at risk for a health condition that is exacerbated by the individual's physical living environment	No	Yes	No	No
	Medical necessity of home remediation service	No	Yes	No	No
2.2b Medically necessary home modifications: Medically necessary air conditioners, heaters, humidifiers, dehumidifier	Previous heat-related illness requiring emergency room or urgent care visit, within the last 12 months that……that occurred at home	Yes; Previous heat-related illness requiring emergency room or urgent care visit, within the last 12 months included in ESMF	Yes	Yes; **Required only for "occurred at home"** portion of criteria, in addition to either ESMF data OR Provider attestation for remainder of criteria	No
	Previous cold-related illness requiring emergency room or urgent care visit within last 12 months that……that occurred at home	Yes; Previous cold-related illness requiring emergency room or urgent care visit, within the last 12 months included in ESMF	Yes	Yes; **Required only for "occurred at home"** portion of criteria, in addition to either ESMF data OR Provider attestation for remainder of criteria	No
	Chronic condition (such as, diabetes, congestive heart failure (CHF), chronic kidney	Yes	Yes	No	No

	disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS)				
	Individuals regularly taking medications or have an otherwise stated condition that interferes with daily thermoregulation	Yes	Yes	No	No
2.2c Medically necessary home modifications: Refrigeration units	Member is a pregnant person/postpartum that requires refrigeration for breast milk	Yes	No	Yes	No
	Prescribed medication requiring refrigeration for the management of a chronic condition	No	Yes	No	No
	Enteral or parenteral nutrition	Yes	Yes	No	No
2.3 Asthma Remediation	One or more hospital inpatient stays(s) related to asthma within the last 12 months	Yes	Yes	No	No
	Two or more ED visits related to asthma within last 12 months	Yes	Yes	No	No
	Three or more urgent care visits related to asthma within the last 12 months	Yes	Yes	No	No
	Two or more prescribing events for oral steroid use related to an asthma diagnosis within the last 12 months	Yes	Yes	No	No
	Three to eleven prescribing events for rescue inhaler including albuterol within the last 12 months	Yes	Yes	No	No
2.4 Medical Respite (Recuperative Care) - Pre and Post Hospitalization	Requiring pre-surgical or procedure care as indicated by a medical professional	No	Yes; **Required**	No	No
	Admission or discharge from an Acute Care hospitalization related to a health condition or illness, 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	No	Yes; **Required**	No	No
	Member is homeless as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	No	Yes	No	Yes Acceptable forms of documentation include one document from the list below: • Written observation by the outreach worker • Written referral by another housing or service provider • A court order resulting from an eviction action notifying the

					individual or family that they must leave • For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay Certification by the state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute **and** certification of no permanent housing in last 60 days **and** Documentation of special needs or 2 or more barriers
2.5 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 in the past 90 days	*To be determined*	Yes	No	No
	Member is homeless as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	No	Yes	No	Yes Acceptable forms of documentation include one document from the list below: • Written observation by the outreach worker • Written referral by another housing or service provider • A court order resulting from an eviction action notifying the individual or

					family that they must leave • For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay • Certification by the state or local government that the individual or head of household seeking assistance met the criteria of homelessness under another federal statute **and** certification of no permanent housing in last 60 days **and** Documentation of special needs or 2 or more barriers
	Member is a youth transitioning out of the child welfare system including foster care	No	No	No	Yes Acceptable forms of documentation include one document from the list below: • Statement from state or county agency verifying Member is involved in Child Welfare is in or was in their custody • Statement from agency responsible for Member's placement verifying they are or were in the custody of the State

					• Copy of court documents/order verifying the Member is in or was in the custody of the state or county • Copy of Foster Care Transition plan
2.6 Utility Setup / Assistance	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 in the past 90 days	*To be determined*	Yes	No	No
	Member is homeless as defined by 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	No	Yes	No	Yes Acceptable forms of documentation include one document from the list below: • Written observation by the outreach worker • Written referral by another housing or service provider • A court order resulting from an eviction action notifying the individual or family that they must leave • For individual and families leaving a hotel or motel – evidence that they lack the financial resources to stay • Certification by the state or local government that the individual or head of household seeking

					assistance met the criteria of homelessness under another federal statute **and** certification of no permanent housing in last 60 days **and** Documentation of special needs or 2 or more barriers
	Youth transitioning out of the child welfare system including foster care	No	No	No	Yes Acceptable forms of documentation include one document from the list below: • Statement from state or county agency verifying Member is involved in Child Welfare is in or was in their custody • Statement from agency responsible for Member's placement verifying they are or were in the custody of the State • Copy of court documents/ order verifying the Member is in or was in the custody of the state or county • Copy of Foster Care Transition plan
2.7 Pre-tenancy services	Any Enhanced Population who is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	*Refer to pathways per each Enhanced Population and homelessness above*			

2.8 Community Transitional Services	Any Enhanced Population who is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	*Refer to pathways per each Enhanced Population and homelessness above*			
2.9 Tenancy Sustaining Services	Any Enhanced Population who is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	*Refer to pathways per each Enhanced Population and homelessness above*			
2.10 Housing Transition and Navigation Services	Any Enhanced Population who is homeless or at risk of becoming homeless as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except for the annual income requirement in 24 CFR 91.5 (1)(i).	*Refer to pathways per each Enhanced Population and homelessness above*			
3.1 Nutritional Counseling and Education	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
3.2a Medically Tailored Meals	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), or	Yes	Yes	No	No
3.2b Clinically Appropriate home delivered Meals	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
3.4 Fresh Produce and Non-Perishable Groceries (Pantry Stocking)	Limited to the following Enhanced Populations: • Pregnant and postpartum persons • High-risk children under the age of 18 (including justice- involved youth, foster care youth, and those under kinship care)	*Refer to pathways per each Enhanced Population above*			
3.5 Cooking Supplies	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			
4.1 Transportation related to HRSN service or care management	Any Enhanced Population	*Refer to pathways per each Enhanced Population above*			

vi. 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 5-16: 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
	3.2a Medically Tailored Meals, and 3.2b Clinically Appropriate Home Delivered Meals
	3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions
	3.4 Fresh Produce and Non-perishable Groceries (Pantry Stocking)
	3.5 Cooking Supplies
Transportation	4.1 Transportation Services

1. Care Management

Care Management involves Eligibility Assessment, planning, education, outreach, facilitation, 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. Social Care Navigators can perform Care Management for the enhanced population.

Care Management for either Navigation services or Enhanced HRSN Services will begin immediately by the SCN for any Medicaid Member that is assessed to have an unmet HRSN based on responses to the questions inthe AHC HRSN Screening Tool.

1.1 **Navigation Services, and**

Medicaid FFS Members who have an identified unmet HRSN and Medicaid Managed Care Members who have an identified 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 5-17: Navigation eligibility and service details

Navigation eligibility and service details	
Eligibility	1. Medicaid FFS Members who have an identified unmet HRSN; or 2. Medicaid Managed Care Members who have an identified unmet HRSN but do not meet the criteria for populations eligible for Enhanced HRSN Services *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.* 3. This is not used for the enhanced population.
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 5-18: 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 5-13 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
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 monthly units is at or below the aggregate service cap as outlined in the HRSN Fee Schedule 3. Social Care Navigators will provide Care Management related to HRSNs only and will not provide any clinical Care Management 4. Care Management is the equivalent of navigation under the non-enhanced population.
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 federal, state, and local services.

Table 5-19: 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. Written approval must also be obtained if the Member owns their residence. An assessment of the qualified Medicaid Member's primary dwelling 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 dwelling assessment and recommended services must be documented in the Social Care Plan and the Statement of Work (SOW) must be approved by the Social Care Navigator. The Member's Social Care Plan should include the approved and completed services.

Table 5-20: 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 5-12 and Social Risk Factors in Table 5-13; 2. Meets the clinical criteria in Table 5-14; 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. *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. If applicable, Social Care Navigators must document the qualifying clinical criteria for home and safety modifications in the Member's Social Care Plan. 2. Modification services are limited to those that are of direct medical or remedial benefit to the Medicaid Managed Care Member. 3. Total combined costs of services for Home Accessibility and Safety Modifications and Home Remediation services may not exceed per Member cap listed in HRSN Fee Schedule for duration of Waiver period.
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 Lead Entity will need to create a unique workflow for Home Accessibility / Safety Modification Services based on the dwelling assessment, which includes a Statement of Work (SOW). In general, the workflow should follow the below steps (see Figure 5-6 for a visual process flow):

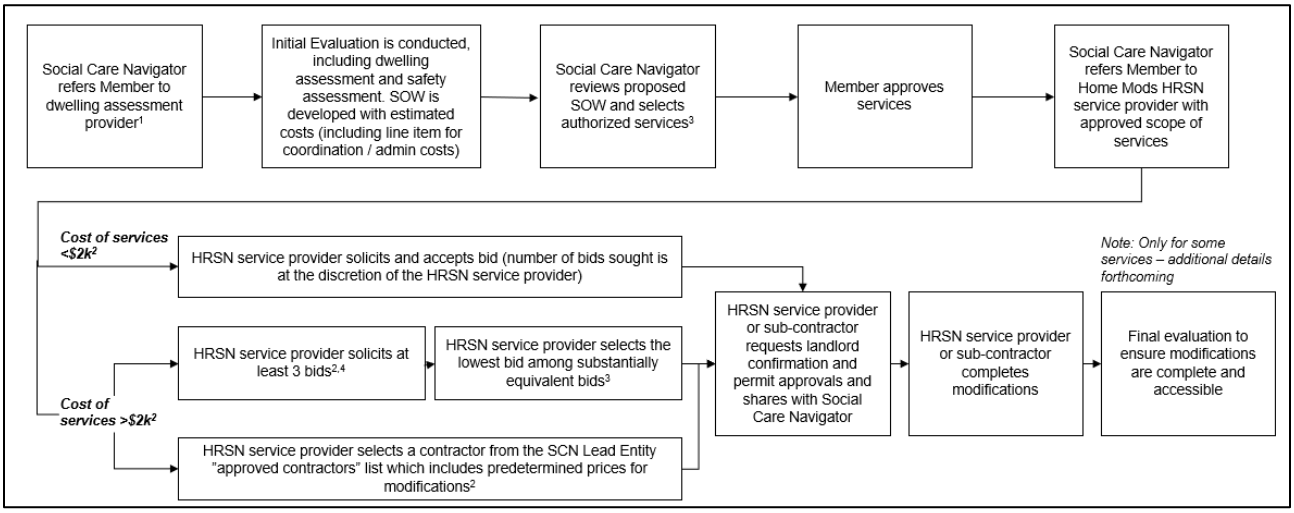
1. Social Care Navigator conducts Screening and Eligibility Assessment with the Member
2. Social Care Navigator records in the Social Care Plan what Enhanced HRSN Services the Member is eligible for, any new clinical or social risk criteria required for Enhanced HRSN Services, and all other relevant questions related to Social Care Plan.
3. If the Member is eligible for Home Accessibility / Safety Modification services, the Social Care Navigator will proceed with assigning the appropriate ICD/SNOMED code, which will trigger a Referral for the Social Care Navigator to select a HRSN service provider to complete a dwelling assessment.
   The HRSN service provider for the dwelling assessment will accept or decline the Referral.
4. If the HRSN service provider accepts the Referral, they will contact the Member to initiate an initial evaluation, including a dwelling assessment of the qualified Medicaid Member's residence to determine the physical adaptations and modifications necessary to ensure maximum health, welfare, and safety, or to allow the Member to function independently in their home and a safety assessment to identify any potential issues that may hinder the completion of the home modification/adaptation service and ensure that the proposed modifications/adaptations would not negatively impact building safety or function. The dwelling assessment and safety assessment may be performed by the same provider in the same visit, or separately.
5. After completion of the initial evaluation, including the dwelling assessment, the HRSN service provider will update the SCN IT Platform demonstrating the initial evaluation and dwelling assessmenthave been completed and provide the Social Care Navigator with an SOW that details recommended services and estimated costs, including a line item for administrative, evaluation, and/or coordination costs. The total cost for Home Accessibility/Safety Modification services must be at or below the allowable cap amount in the HRSN Fee Schedule. If recommended services are above the allowable cap, the Social Care Navigator must prioritize approved services to remain under the cap.
6. The Social Care Navigator will review the SOW and select the appropriate services to authorize for the Member to receive (Note: HRSN service provider may recommend services that are not covered under the NYHER Enhanced HRSN Services. In those instances, the Navigator may connect Member to applicable federal, state, local programs). If the Member is renting their residence, the HRSN service provider will bring the final determination to the Member and landlord for written approval for services to begin or for installation. Written approval must also be obtained if the Member owns their residence.
7. The Social Care Navigator will document the authorized services within the Social Care Plan and notify the HRSN service provider of the authorized SOW.
8. The HRSN service provider or subcontractor that will be providing services in the SOW follows up with the Member to schedule and conduct the services. The HRSN service provider or subcontractor proceeds with completing the services outlined in the SOW. Some services may require the completion of a final evaluation after service completion to ensure the modifications are complete and accessible to the Member – *additional details will be shared by OHIP.*

9. The HRSN service provider updates the SCN IT Platform to demonstrate the services within the SOW have been completed.
10. 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.
11. The Social Care Navigator proceeds with issuing a completed Social Care Claim to the MCO for tracking purposes
12. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the HRSN service provider based on a fee-for-service reimbursement model.

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

- **a.** Obtain at least three bids for any total work of $2,000 or more and select the lowest price and best value or substantially equivalent bid, if applicable
- **b.** If preferred, the SCN Lead Entity can establish a list of preferred contractors through a competitive bidding process to be updated annually, and the HRSN service provider can select a contractor for recommended modifications from this list without soliciting at least 3 bids for each service

Figure 5-6: Process flow for home modification services



[1]Providers for evaluations to be consistent with NHTD Waiver requirements
[2]Consistent with NHTD bidding threshold
[3]Contracted Network organization may suggest services that are not covered under the SCN Enhanced HRSN Services. SCN Lead Entity may refer the Member to ONLY the approved Enhanced HRSN Services
[4]Must demonstrate reasonable effort to acquire 3 bids, "Reasonableness" requirement for acquiring 3 providers will not be defined by OHIP

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.

Total combined costs of services for Home Accessibility and Safety Modifications and Home Remediations may not exceed per Member cap listed in HRSN Fee Schedule for duration of Waiver period.

These services and provisions in 2.2a, 2.2b and 2.2c are available in a home that is owned, rented, leased, or occupied by the eligible Medicaid Member or their caregiver. 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. Written approval must also be obtained if the Member owns their residence. An assessment of the qualified Medicaid Member's primary dwelling should be conducted to determine the home remediation services or provisions necessary to ensure maximum health, welfare, and safety.

Outcome of dwelling assessment and recommended services must be documented in the Social Care Plan and the Statement of Work (SOW) must be approved by the Social Care Navigator. The Member's Social Care Plan should include the approved and completed services.

2.2a Mold and Pest Remediation

Home remediation services to promote member's health and wellbeing may include:

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

2.2b Ventilation Improving Systems

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

- Air conditioners;
- Humidifiers;
- Dehumidifiers;
- Heaters;
- Air filtration devices (which may be limited to mechanical only).

2.2c Equipment Provision

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

Table 5-21: 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 5-12 and Social Risk Factors in Table 5-13; 2. Meets the clinical criteria in Table 5-14; 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 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Social Care Navigator must document the qualifying clinical criteria (Table 5-14) 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 4. Total combined costs of services for Home Accessibility and Safety Modifications and Home Remediation services may not exceed per Member cap listed in HRSN fee schedule for duration of Waiver period.
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 Services

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

1. Social Care Navigator conducts Screening and Eligibility Assessment with the Member
2. 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).
3. If the Member is eligible for Home Remediation service, the Social Care Navigator will proceed with assigning the appropriate ICD 10 Z-codes/SNOMED code that will trigger a Referral for the Social Care Navigator to select a contracted HRSN service provider for a dwelling assessment. The contracted HRSN service provider will accept or decline the Referral for a dwelling assessment and initial evaluation.
4. If the contracted HRSN service provider accepts the Referral, the HRSN service provider will contact the Member to initiate the initial evaluation, including a dwelling assessment of the qualified Medicaid Member's residence to determine the physical adaptations and modifications necessary to ensure maximum health, welfare, and safety, or to allow the Member to function independently in their home

and a safety assessment to identify any potential issues that may hinder the completion of the home remediation service and ensure that the proposed remediations would not negatively impact building safety or function. The dwelling assessment and safety assessment may be performed by the same provider in the same visit, or separately.

5. After completion of the initial evaluation, including the dwelling assessment, the HRSN service provider will update the SCN IT Platform demonstrating the dwelling assessment and initial evaluation have been completed and provide the Social Care Navigator with a SOW with recommended services and estimated costs, including a line item for administrative, evaluation, or coordination costs.
6. The Social Care Navigator will review the SOW and select the appropriate services to authorize for the Member to receive. (Note: HRSN service provider may recommend services that are not covered under the NYHER Enhanced HRSN Services. In those instances, the Navigator may connect Member to applicable federal, state, local programs). If the Member is renting their residence, the HRSN service provider will bring the final determination to the Member and landlord for written approval for services to begin or for installation. Written approval must also be obtained if the Member owns their residence.
7. The Social Care Navigator documents the authorized services within the Social Care Plan and notifies the HRSN service provider that the SOW is authorized
8. The HRSN service provider or subcontractor proceeds with completing the work outlined in the approved SOW. Some services may require the completion of a final evaluation after service completion to ensure the modifications are complete and accessible to the Member – *additional details will be shared by OHIP.*
9. The HRSN service provider updates the SCN IT Platform to demonstrate the services have been completed
10. 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
11. The Social Care Navigator proceeds with issuing a completed Social Care Claim to the MCO for tracking purposes
12. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the HRSN service provider based on a fee-for-service reimbursement model.

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

a. Obtain at least three bids for any total work of $2,000 or more and select the lowest price and best value or substantially equivalent bid, if applicable
b. If preferred, the SCN Lead Entity can establish a list of preferred contractors through a competitive bidding process to be updated annually, and the HRSN service provider can select a contractor for recommended modifications from this list without soliciting at least 3 bids for each service.

2.3 **Asthma Remediation**

Remediation services will be available to Enhanced Population Members having a diagnosis of asthma and meeting the clinical criteria in Table 5-14. 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 should address multiple triggers to improve the residence 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 as outlined below.

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

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

b. **Initial Evaluation, including Dwelling Assessment:** An initial evaluation will be conducted, including a comprehensive dwelling assessment of the primary residence to identify home remediations needed to reduce or eliminate asthma triggers and improve the indoor environment of the dwelling and a safety assessment to identify any potential issues that may hinder the completion of the home modification/adaptation service and ensure that the proposed modifications/adaptations would not negatively impact building safety or function. The dwelling assessment and safety assessment may be performed by the same provider in the same visit, or separately. The SOW should be developed by a qualified home improvement contractor, incorporate results and relevant findings from the dwelling assessment and initial ASME visit, and be approved by the Social Care Navigator. If the Member is

renting their residence, the Dwelling Assessor must obtain written approval from the Member and from the landlord for any invasive installation work to be performed in a rented residence. A written approval will also be needed if the Member owns their own residence.

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 reviewed by the Social Care Navigator 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. Total costs of services for Asthma Remediation may not exceed per Member cap listed in the HRSN Fee Schedule for duration of Waiver period

d. **Final evaluation:** Some services may require the completion of a final evaluation after service completion to ensure the home remediations are complete and accessible to the Member – *additional details will be shared by OHIP.*

Table 5-22: 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 o Whole-house fan • Heating unit clean and tune, repairs, or replacement • Forced air-furnace filter replacement and provision of (6) additional filters • Installation / repair of exhaust fan (kitchen and bathroom) • Dryer venting and cleaning • Air duct maintenance • Carpet steam cleaning • Insulation • Air sealing • Replacement of air filters in HVAC system	Provision of: • Hygrometer (Humidity gauge) • Microfiber cleaning cloths • Green scrubbers • Cleaning buckets and spray bottle • Microfiber mop • Castile soap • Cleaning vinegar (with recipe for mixing)
Mold Remediation and Moisture Control	*Indoor Allergen Reduction*
Provision of: • Plumbing repairs to support moisture control and water damage • Repairs to boilers (steam and water) • Repairs to condensate drain • Basement water proofing (coatings, drainage systems) • Sum pump repair / replacement	Provision of: • Vacuum with HEPA filter and filter replacements • Allergen impermeable pillow and mattress encasement

• Carpet removal or removal of moldy wet flooring and installation of Asthma-friendly flooring • Dirt floor vapor barrier basement / crawlspace • Cleaning / repair / installation of gutter downspout system and gutter screens • *Mold remediation (less than 10 square feet) • *Mold remediation (greater than 10 square feet)	
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."*

Accessibility and Safety Modifications: Air conditioners, humidifiers and air filtration devices (limited to mechanical only) will be available to eligible Members eligible for Asthma Remediation. These services will be funded under Home Accessibility and Safety Modifications. Members may be assessed and deemed eligible by a Social Care Navigator for additional services under Home Accessibility and Safety Modifications, services will be connected to corresponding funding caps.

Table 5-23: Asthma Remediation: eligibility and service details

Asthma Remediation eligibility and service details	
Eligibility	1. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 5-12 and Social Risk Factors in Table 5-13; 2. Meets the clinical criteria in Table 5-14; 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 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Social Care Navigator 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 residence 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 6. Total costs of services for Asthma Remediation may not exceed per Member cap listed in the HRSN Fee Schedule for duration of Waiver period.
Allowable Providers	• Contracted asthma remediation service providers that are designated as a non-profit Community Based Organization 501 (c)(3) or 501(c)(4) • Asthma Remediation service may be performed by a contracted 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 • 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 proof of credentials/ licensure and/or industry-accepted certifications and training specific to the services being proposed and 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 services including pesticide application must be delivered by professionals licensed by the NYS Department of Environmental Conservation.

Workflow for Asthma Remediation Service

The SCN Lead Entity will need to create a unique workflow for the Asthma Remediation Service given the multiple service components of asthma self-management education, dwelling assessment, and associated Statement of Work (SOW), and home remediation and provision of supportive products. In general, the workflow should follow the below steps (see Figure 5-8 for a visual process flow):

1. Social Care Navigator(s) conducts Screening, and Eligibility Assessment with the Member.
2. 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).
3. 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 HRSN service provider to complete Asthma Remediation service components.

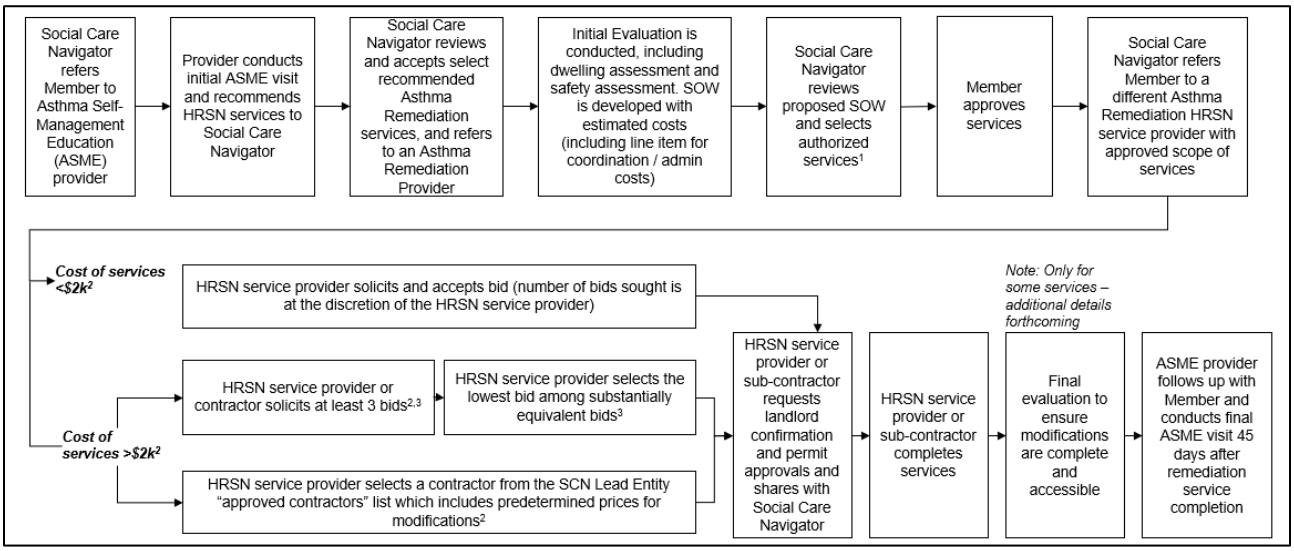
4. The HRSN service provider, for component a., will accept or decline the Referral.
5. If the HRSN service provider accepts the Referral, they will contact the Member to initiate component a. After completion of the initial visit under component a, the HRSN service provider will report the recommended HRSN services back to the Social Care Navigator and update the SCN IT Platform demonstrating the initial services have been completed.
6. The Social Care Navigator reviews the HRSN service provider's findings and recommendations and confirms completion of initial ASME visit criteria. The Social Care Navigator then proceeds with securing a HRSN service provider to conduct components b. and c.
7. The HRSN service provider will be directed to conduct the initial evaluation, including a dwelling assessment for component b.: Initial Evaluation, including Dwelling Assessment and provide the SOW to the Social Care Navigator. The total cost for asthma remediation services must be at or below the allowable cap amount in the HRSN fee schedule. If above the allowable cap, Social Care Navigator must prioritize approved services to remain under the cap.
8. The Social Care Navigator will review the SOW and select the appropriate services to authorize for the Member to receive. (Note: HRSN service provider may recommend services that are not covered under the SCN Lead Entity Enhanced HRSN Services.) If the Member is renting their residence, the HRSN service provider will bring the final determination to the Member and landlord for written approval to begin services or installation. Written approval must also be obtained if the Member owns their residence.
9. The Social Care Navigator documents the authorized services within the Social Care Plan and notifies the HRSN Service provider of the authorized SOW.
10. The HRSN service provider or subcontractor proceeds with completing component c.: Home Remediation and Provision of Supportive Products (if applicable) and d.: Final evaluation (if applicable). The HRSN service provider updates the SCN IT Platform to demonstrate the services have been completed. The Social Care Navigator notifies the HRSN Service provider for component a. of the SOW completion date. The HRSN Service provider for component a., follows up with the Member to schedule and conduct the final visit 45 days after Asthma Remediation services have been completed.
11. The HRSN Service provider updates the SCN IT Platform to demonstrate the final services under component a. have been completed.
12. 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
13. The Social Care Navigator proceeds with issuing a completed Social Care Claim to the MCO for tracking purposes
14. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the HRSN service provider based on a fee-for-service reimbursement model.

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

a. Obtain at least three bids for any total work of $2,000 or more and select the lowest price and best value or substantially equivalent bid, if applicable;
b. If preferred, the SCN Lead Entity can establish a list of preferred contractors through a competitive bidding process to be updated annually, and the HRSN service provider can

select a contractor for recommended modifications from this list without soliciting at least 3 bids for each service.

Figure 5-8: Process flow for asthma remediation services



2.4 **Recuperative Care (Medical Respite)**

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

Recuperative care may be used as:

a. **Short-term Post-Hospitalization Care** – provided to eligible Members transitioning out of institutions (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 5-24: 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 5-12 and Social Risk Factors in Table 5-13; 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
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, but cannot exceed 30 days per year. • Eligible settings for recuperative care (i.e., short-term Pre-Procedure and Post-Hospitalization) must have staffing sufficient in number and qualification to render all required medical respite services in accordance with the NYS established Medical Respite regulations (10 NYCRR Part 1007) and relevant program guidance
Allowable Providers	• State-certified Medical Respite providers who are contracted with the SCN Lead Entity

Workflow for Medical Respite Service

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

1. Hospitals, Clinics, HRSN service providers, and ecosystem partners will send the Member's Referral for Medical Respite Program (MRP) services directly to the regional SCN Lead Entity, without HRSN Screening or Eligibility Assessment (See below for elements that must be included in this referral)
2. Social Care Navigators should prioritize MRP Referrals and strive for a rapid turnaround of 2 business days to outreach the Member to complete Screening and Eligibility Assessment. The Social Care Navigator will conduct screening and Eligibility Assessment with the Member (if not already completed by the referring entity). The clinical criteria required per NYHER can be sourced from the referring entity's Referral package.
3. Based on the Social Care Navigator's Eligibility Assessment, the SCN's Social Care Navigator will either:
    a. **Reject the Referral** if the Member does not meet NYHER eligibility criteria. The SCN IT Platform will have the ability of recording the rejection as coming from the Social Care Navigator. The Social Care Navigator will notify the referring entity of the rejection **OR;**
    b. **Accept the Referral** if the Member meets NYHER eligibility criteria. The Social Care Navigator will refer the Member to a local contracted MRP (For timing requirements, see *HRSN capacity and access guidelines and requirements*.)
4. The MRP will then conduct their regulatory Assessment which may be in person in accordance with the NYS established regulations and MRP guidance. The MRP will accept the referral within the number of days listed in Section ii. HRSN capacity and access guidelines and requirements. Based on the MRP Regulatory Assessment, the MRP will either:
    a. **Reject the SCN's Referral.** If the MRP rejects the Social Care Navigator's Referral (due to capacity, individual is not appropriate for facility, etc.), the Social Care Navigator will either initiate a referral to another MRP that may accept the Member or, when attempts have been exhausted, notify the referring entity and the Member of the unsuccessful attempts to find an appropriate MRP. 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, the MRP will determine an appropriate length of stay. The MRP will proceed with SCN IT Platform requirements to accept the Social Care Navigator's Referral request
5. The Social Care Navigator notifies the referring entity that the MRP accepts the Referral
6. The Social Care Navigator documents the referred MRP services within the Member's Social Care Plan which will include start date, service duration, indication of pre or post respite stay and pre-determined date to follow up with the Member on any other recommended HRSN services
7. The MRP proceeds with rendering their services, documents relevant notes into the SCN Social Care Plan including estimated discharge date in the SCN IT Platform
8. The Social Care Navigator documents the completed services within the Social Care Plan and follows up with the Member / MRP to document the Member's satisfaction. The SCN will work closely with the MRP and offer collaborative assistance with care coordination including additional transitional HRSN services prior to the discharge date (where the Member qualifies for additional Enhanced HRSN Services)
9. The SCN Lead Entity proceeds with issuing reimbursement (from PMPM payments) to the MRP on the HRSN fee schedule-based reimbursement basis
10. The SCN Lead Entity proceeds with issuing a completed Social Care Claim to the MCO for completed service (for tracking purposes only)

Referring entity's Referral package

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

Basic demographic and identifying information, such as:

1. Name;
2. Date of birth;
3. Social security number (if available);
4. Copies of any available government-issued documentation (such as driver's license, non-driver ID, or immigration papers); and
5. Health coverage status (including a copy of any pending application for coverage, if applicable).
6. Indication of NYHER Eligibility for Medical Respite:
    - 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

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

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

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

Medical records that address:

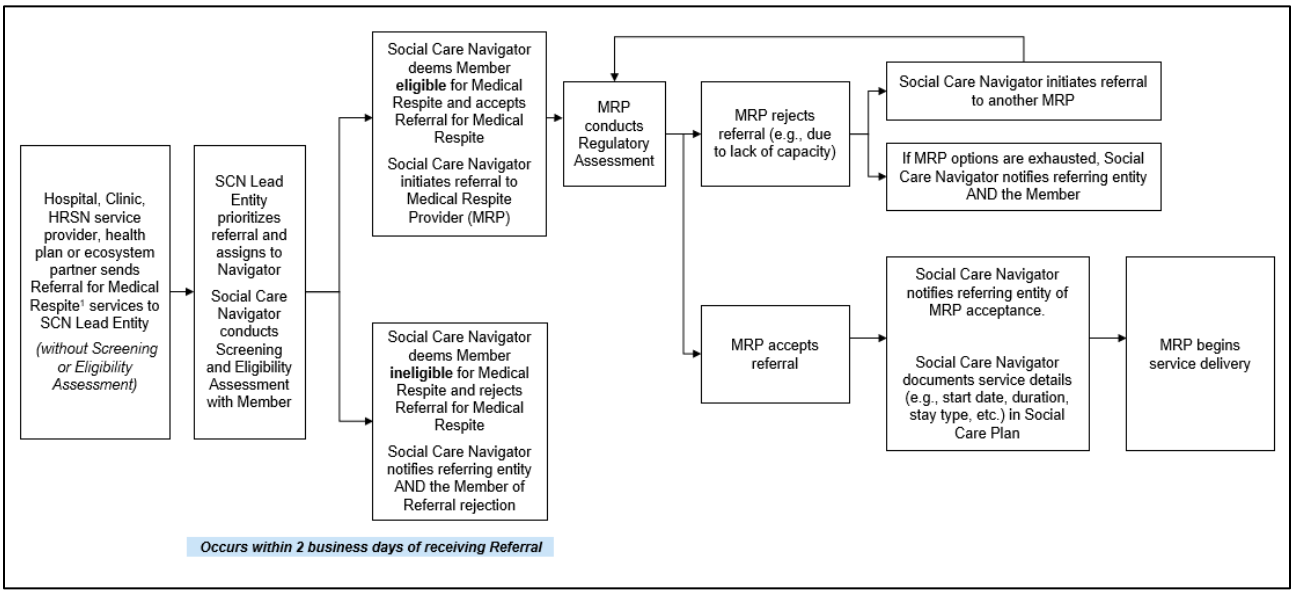
- The individual's diagnosis;
- Pertinent medical history;
- Results of diagnostic tests or screenings; and
- Current or recommended interventions, including post-acute care and medications.

The referring entity must conduct 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:

- Information to support the provider's conclusion that the individual is experiencing homelessness or at risk of homelessness, including the individual's current living situation or situation prior to being admitted to a facility;

- Description of the individual's physical limitations, if applicable, and any reasonable accommodations that may be required of the medical respite program;
- Confirmation that the individual can perform ADLs with no or minimal assistance *or* provision of a physician order for certified home health agency services;
- Confirmation that the individual is self-directing *or* receives at least part-time supervision from a self-directing individual or entity that is responsible for making decisions related to the individual's ADLs; and
- Confirmation that the individual is not, at the time of Referral, a threat of harm to their self or others

Figure 5-9: Process flow for medical respite services



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

2.5 **Rent / Temporary Housing**

Rent / Temporary Housing includes payment for rent and/or short-term, temporary stays and the security deposit 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 (including rental payments that have utility costs incorporated into the rental rate) up to the U.S. Department of Housing and Urban Development (HUD) Fair Market Rate.

Payment for housing services (e.g., rent payments) should not be paid directly to a Member. The SCN should provide payment to the entity providing the Enhanced HRSN service or housing provider (e.g., HRSN service provider, housing management agency, landlord).

Table 5-25: 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 5-12 and Social Risk Factors in Table 5-13 and 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Rent / temporary housing services are limited to up to six months for the duration of the Waiver . The Social Care Navigator must ensure that the Member is connected to other programming or permanent housing through available local, state, and federal programs by the end of the six-month period 2. Social Care Navigator 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. Social Care Navigators 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 Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. See *HRSN Network Capacity and Access* section for details 3. Housing service providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.6 **Utility Setup / Assistance**

Utility setup and assistance is limited to Members receiving rent / temporary housing service per **Section 2.5: Rent / Temporary Housing** above. Qualified Members may be eligible for assistance with setting up utility services in their new community living setting. Utility setup and assistance services may include one-time activation costs, back payments to secure utilities, and payment of up to six (6) months of utility costs.

This service provides payment for recurring utilities costs for up to six (6) months. Eligible members may receive a one-time payment assistance with utility activation fees and/or back payment up to a capped amount, as listed in the HRSN Fee Schedule. This service will cover expenses for the following types of utility payments:

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

a. Utility Activation: Provides payment for non-refundable, non-recurring utility set-up costs or restart costs if the service has been discontinued.

b. Utility Back payments: Provides one-time payment, up to a capped amount, for utility back payments

c. Utility Assistance: Covers up to 6 months of utility costs

Table 5-26: 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 5-12 and Social Risk Factors in Table 5-13 2. Meets the clinical criteria in Table 5-14 3. Must be receiving rent / temporary housing services as described in Section 2.5 on rent / temporary housing *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Utility Setup / Assistance is limited to up to 6 months per demonstration 2. Utility activation fees and/or back payment is limited to a one-time payment assistance, up to a capped amount. 3. Utility Setup / Assistance is limited to individuals receiving rent / temporary housing 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 Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. See *HRSN Network Capacity and Access section for details* 3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.7 Pre-tenancy Services

Medicaid Managed Care Members may qualify for pre-tenancy services under this 1115 Waiver authority, for up to 6 months. These services include:

- Assistance with navigating the complexities of the housing application and supporting the Member when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews.
- Assistance with the housing search and application process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance.

Table 5-27: 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 5-12 and Social Risk Factors in Table 5-13 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Services are limited to no more than six months,
Allowable Providers	1. Contracted pre-tenancy housing service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted pre-tenancy housing services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. See *HRSN Network Capacity and Access* section for details 3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.

2.8 **Community Transitional Supports (CTS)**

Services are intended to assist Members who have secured a new housing unit to have a smooth and seamless transition to community living. Member must be assessed and their need for any of the following services should be documented in the Social Care Plan. Assistance with the set-up of the new housing unit and review of the living environment to ensure that it meets the Member's clinical, furnishings, adaptive aids, environmental modifications, and food and clothing needs at transition. Total costs of services may not exceed per Member cap listed in the HRSN fee schedule for duration of Waiver period. The following one-time transition and moving costs are included:

- Security deposit, , and brokerage fees;
- Utility activation fees, movers, and relocation expenses;

- Pest eradication and inspection fees;
- Pantry stocking food (limited to a maximum of 30 days of food); and
- The purchase of household goods and furniture (pots and pans, bed, mattress, lamps, nightstands, etc.)

Table 5-28: 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 5-12 and Social Risk Factors in Table 5-13 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Service is a one-time expense and does not continue after the individual is stably housed 2. Total costs of services may not exceed per Member cap listed in the HRSN Fee Schedule for duration of Waiver period 3. First month's rent should be paid using rental subsidy service
Allowable Providers	1. Contracted community-based housing service providers, with experience providing Community Transitional Support services that are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted community Transitional Support services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. *See HRSN Network Capacity and Access section for details* 3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.9 **Tenancy Sustaining Services**

Medicaid Managed Care Members may qualify for a range of services to assist in maintaining and sustaining their tenancy in affordable or supportive housing by providing tenant rights education and eviction prevention. Tenancy sustaining services are intended to assist Members in securing housing and have a smooth and seamless transition to community living. Service is limited to 6 months, and Members must be assessed and their need for any of the following services must be documented in the service plan. Under this Waiver authority, tenancy sustaining services will include:

- Assistance in linking to free or affordable legal services for Members facing housing-related issues;
- Connection to available resources to assist in establishing a bank account and paying bills;
- Assistance in connecting the Member with social services to assist with filling out applications and appropriate documentation to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy;

- Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include direct interventions to address risks and 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 5-29: 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 5-12 and Social Risk Factors in Table 5-13 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Tenancy sustaining services does not include the payment of rent or other housing costs 2. Service is limited to six months
Allowable Providers	1. Contracted Tenancy Sustaining community-based housing service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501 (c)(3) or 501(c)(4) non-profit organization 2. Contracted community-based legal service providers, with experience serving the target population that are registered as a 501(c)(3) or 501(c)(4) CBO non-profit organization 3. Contracted Tenancy Sustaining housing services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. *See HRSN Network Capacity and Access section for details* 4. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

2.10 Housing Transition and Navigation Services

Medicaid Managed Care Members may qualify for assistance navigating and transitioning into a new home, for 4 hours per month for a maximum of 6 months. Under this 1115 Waiver authority, housing transition and navigation services will include:

- Assistance with the set-up of a new housing unit, including clinically appropriate residential modifications, and identifying needs for assistance with arranging the move and supporting the details of the move, as appropriate;
- Connection to resources aiding with housing costs and other expenses; including linkages to rental assistance vouchers, security deposits, application fees, moving costs, etc.;

- Review of the living environment to ensure that it meets the clinical needs of the individual and is ready for move-in, including collaborating with the relevant provider staff where the individual is institutionalized (e.g., hospital or facility social worker) to ensure a seamless transition to the community.

Table 5-30: 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 5-12 and social risk factors in Table 5-13 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Services are capped at 4 hours per month for a maximum of 6 months.
Allowable Providers	1. Contracted housing transition and navigation service providers, with experience serving populations eligible for Enhanced HRSN Services that are registered as a 501(c)(3) or 501(c)(4) non-profit organization 2. Contracted housing transition and navigation services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) CBO. (See *HRSN Network Capacity and Access section for details*) 3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing

3. Nutrition 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) and/or Older Americans Act Nutrition Services through Care Management services.

MLTCP and MAP Members are not eligible for 1115 Waiver nutrition services since they are provided as a plan benefit. Pregnant and post-partum individuals and children are eligible for additional nutrition supports where indicated.

Table 5-31: 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

In navigating Members to Enhanced HRSN Services, Navigators should determine the type of nutrition services that are appropriate for each Member based on their unique needs and eligibility criteria. For Members who are eligible for BOTH prepared meals (MTMs or clinically appropriate meals) and groceries (food prescriptions, food vouchers, or pantry stocking), the Navigator should ask the Member the appropriate to determine the most appropriate service for the Member (see Eligibility Assessment Process for specific questions).

3.1 Nutrition Counseling and Education

SCNs will provide nutrition counseling and education services, including topics on healthy meal preparation and connecting the individual with grocery budget resources. Nutrition counseling and education will be provided by Certified Dietitian / Nutritionists, 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 5-32: 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 5-12 and Social Risk Factors in Table 5-13 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*

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 3. Service is available for up to 6 months at a time, with an option for renewal if needed
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

3.2a Medically Tailored Meals

Home delivered prepared medically tailored meals will be available to Medicaid Managed Care Members who have an identified unmet HRSN for 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. Medically tailored meal providers must provide qualified individuals medically appropriate meals designed to meet all of the Member's medical nutritional requirements alongside Medical Nutrition Therapy provided by an RDN to sustain improved health and stability. Nutrition counseling must be available to Members receiving medically tailored meals. Medically tailored meals benefit is designed to be tailored by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) to an individual Member with a chronic condition[2] and/or pregnant or post-partum persons and must adhere to standards informed by established nutrition guidelines, such as the Food is Medicine Coalition (FIMC) MTM nutrition standards, for specific health conditions and tailored to Member's health condition.

Table 5-33: Medically Tailored Meals: eligibility and service details

Medically Tailored Meals: eligibility and service details	
Eligibility	1. Meets at least one of the criteria for Enhanced HRSN Services in Table 5-12 and Social Risk Factor in Table 5-13 2. Cannot prepare their own meals (see Eligibility Assessment Process for specific questions Navigator should ask member to make this determination) 3. Meets the additional clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. This service is limited to three (3) prepared meals a day, seven days a week for up to 6 months at a time 2. Pregnant/postpartum persons may receive these services either throughout their pregnancy and up to 12 months postpartum, or for up to 6 months. Services

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

	may be renewed 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 post-partum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/post-partum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/post-partum periods. 3. 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 eligible household members as determined by individual Screening and Eligibility Assessments. 4. Meals can only be delivered to the enrolled Member's home or private residence 5. Members who receive home delivered medically tailored meals cannot also receive Clinically Appropriate Meals, Pantry Stocking (Fresh Produce and Non-perishable Groceries) or Medically Tailored / Nutritionally Appropriate Food Prescription 6. MTM must adhere to standards informed by established nutrition guidelines, such as the Food is Medicine Coalition (FIMC) MTM Nutrition Standards for specific health conditions, and be tailored to Member's health condition.
Allowable Providers	1. Contracted Home Delivered Meal service providers that are designated as a non-profit Community Based Organization 501 (c)(3) or 501(c)(4) 2. Contracted Home Delivered Meal services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) Community Based Organization. (See *HRSN Network Capacity and Access section for details*) 3. Providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety 4. Medical Tailored Meal providers must also provide Medical Nutrition Therapy with an RDN or CDN to conduct an initial nutritional assessment to determine meal design requirements.

3.2b Clinically Appropriate Home Delivered Meals

Home delivered clinically appropriate meals will be available to Medicaid Managed Care Members who have an identified unmet HRSN for food insecurity and meet specific eligibility requirements. Meal plans will be approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN), and designed to improve health outcomes, lower cost of care, and increase Member satisfaction.

Clinically appropriate meals must provide well-balanced, nutritionally appropriate meals that adhere to evidence-based nutritional guidelines. Clinically appropriate meals promote health and wellness for Enhanced populations who have an unmet HRSN under the food domain and meet the USDA definition of low food security but do not have chronic conditions and are not pregnant/postpartum persons. All meals

provided must be approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN) and must adhere to standards informed by appropriate nutrition guidelines.

Table 5-34: Clinically Appropriate Home Delivered Meals: eligibility and service details

Clinically Appropriate Home Delivered Meals: eligibility and service details	
Eligibility	1. Meets at least one of the criteria for Enhanced HRSN Services in Table 5-12 and Social Risk Factor in Table 5-13 2. Cannot prepare their own meals (see Eligibility Assessment Process for specific questions Navigator should ask member to make this determination) 3. Meets the additional clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. This service is limited to three (3) prepared meals a day, seven days a week for up to 6 months at a time 2. Pregnant/postpartum persons may receive these services either throughout their pregnancy and up to 12 months postpartum, or for up to 6 months. Services may be 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. 3. 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 as determined by individual Screening and Eligibility Assessments 4. Meals can only be delivered to the enrolled Member's home or private residence 5. Members who receive clinically appropriate meals cannot also receive Medically Tailored Meals, Pantry Stocking (Fresh Produce and Non-perishable Groceries) or Medically Tailored / Nutritionally Appropriate Food Prescription 6. Clinically appropriate meals must provide well-balanced, nutritionally appropriate meals that adhere to evidence-based nutritional guidelines.
Allowable Providers	1. Contracted Home Delivered Meal service providers that are designated as a non-profit Community Based Organization 501 (c)(3) or 501(c)(4) 2. Contracted Home Delivered Meal services may be performed by for-profit organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) or 501(c)(4) Community Based Organization. (See *HRSN Network Capacity and Access section for details*) 3. Providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions

Medicaid Managed Care Members who have an identified unmet HRSN 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 only be redeemed at food pharmacies, food pantries, grocery stores, farmer's markets, mobile markets, and Community Supported Agriculture (CSA) subscriptions. Members who opt for food boxes will receive a weekly delivery of food appropriate for complete weekly meals.

If the Member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 12 months postpartum, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply.

Navigators may refer eligible Members for either food boxes or nutrition vouchers based on each Member's preference.

1. Food Boxes

Food boxes will include enough delivered items per box to create an estimated 3 meals a day, 7 days a week (21 meals) with amount of food meeting the Hunger Prevention and Nutrition Assistance Program (HPNAP) recommendations. Food boxes should follow appropriate nutritional standards.

2. Nutrition Vouchers

Vouchers will have a stated dollar amount to reasonably cover the cost of preparing 21 nutritious meals per week.

Table 5-35: 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 5-12 and social risk factors in Table 5-13 and 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. This service is limited to weekly delivery of food appropriate for complete weekly meals 2. This service is limited to three (3) prepared meals a day for up to 6 months at a time 3. Pregnant/postpartum persons may receive these services either throughout their pregnancy and up to 12months postpartum, or for up to 6 months. Services may be 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 eligible household members as determined by individual Screening and Eligibility Assessments. 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
Allowable Providers	1. Contracted Medically tailored or nutritionally appropriate food prescription providers that are designated as a non-profit Community Based Organization 501(c)(3) 2. Contracted Medically tailored or nutritionally appropriate food prescription providers may be offered by for-profits organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) CBO. *(See HRSN Network Capacity and Access section for details*) 3. Providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

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

Medicaid Managed Care Members who have an identified unmet HRSN 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. Pantry stocking cannot include perishable dairy or meat items. Provision of this service is limited to high-risk children under age 18 and pregnant/postpartum persons, for up to six months. Pregnant individuals, as defined in Table 5-12, 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 3 meals/day, 7 days/week, and the amount of food meeting the Hunger Prevention and Nutrition Assistance Program (HPNAP) recommendations. Pantry stockings will be delivered/picked up to the Member in a weekly box. Pantry stocking will not include meat or dairy products. OHIP recommends that food items provided in pantry stocking are nutritionally appropriate (e.g., fresh, frozen, canned fruits and vegetables; plant-based proteins; dried goods; seasonings; spices).

Table 5-36: 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 5-12 and social risk factors in Table 5-13 and 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	• Pantry stocking service is limited to high-risk children under age 18 and pregnant/postpartum individuals who qualify under criteria in Table 5-12 • 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 Social Care Navigator • Pregnant/postpartum persons may receive these services either throughout their pregnancy and up to 12 months postpartum, or for up to 6 months. Services may be renewed 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 eligible household members as determined by individual Screening and Eligibility Assessments. 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 Lead Entity'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 have an identified unmet HRSN for food insecurity may qualify for cooking supplies that are necessary for meal preparation and nutritional welfare when not available through other programs. Service is available up to a capped per Member amount, as determined by each SCN Lead Entity, and can include:

- Kitchenware (e.g., plates, utensils, mixing bowls, pots and pans, etc.)
- Microwave
- Mini refrigerator*

*The refrigerator listed in this section is independent from the medical refrigerator available under Housing Service.

Table 5-37: 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 5-12 and social risk factors in Table 5-13 and 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
Service Limitations and Restrictions	1. Medicaid Managed Care Members may not qualify for this service if provision for cooking supplies is being offered by another program or if the Member received Community Transitional Supports authorized under this 1115 Waiver 2. Service is available up to a capped per Member amount, as listed in the HRSN Fee Schedule
Allowable Providers	1. Contracted Cooking Supply service providers that are designated as a non-profit Community Based Organization 501(c)(3) 2. Contracted Cooking Supply service providers may be offered by for-profits organizations at the SCN Lead Entity's discretion in absence of an available 501(c)(3) Community Based Organization. (*See HRSN Network Capacity and Access section for details).* 3. Nutrition services providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety

4. Transportation

4.1 Transportation Services

Transportation services may be available to eligible Medicaid Managed Care Members who have an identified unmet HRSN and meet the social risk factors and clinical criteria required for Enhanced HRSN Service under this 1115 Waiver.

Table 5-38: 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., taxi/livery, rideshare/Transportation network company (TNC), public transportation) to utilize Enhanced HRSN Services and/or care management activities for which they have been referred. The Member's need for transportation services must be documented in their Social Care Plan.

Examples of Enhanced HRSN Services include HRSN-related activities such as:

- Housing appointments;
- Housing court (eviction prevention);
- Local Department of Social Services / Vital Records appointments;
- Local Department of Motor Vehicles appointments;
- Education and support for chronic conditions;
- Court, probation, parole, and order of protection-related appointments;
- Childcare / Parenting classes; and
- Transportation to food pharmacies, farmer's markets, mobile markets, etc.

The Social Care Navigator, who is directly involved in addressing the Member's HRSN needs, will determine the most cost-effective and appropriate mode of transportation to meet the unique needs of each Member. If a Medicaid Member uses the public transit system for the activities of daily life, then, in most circumstances, transportation for the Member should be requested at a mode of transportation no higher than that of the public transit system. Service is available for a maximum duration of 6 months, with possibility of re-authorization.

Transportation planning is the responsibility of, and can be billed for by, the Member's Social Care Navigator. The HRSN service provider should be reimbursed for only the costs of transport.

Table 5-39: 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 5-12 and social risk factors in Table 5-13 and 2. Meets the clinical criteria in Table 5-14 *Please refer to* https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm *for the latest eligibility criteria.*
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 • Service is available for a maximum duration of 6 months, with possibility of re-authorization
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 Lead Entity's discretion in absence of an available 501(c)(3) Community Based Organization. (*See HRSN Network Capacity and Access section for details).* • All Contracted Transportation service providers must have a valid: New York or other valid state driver license, vehicle registration, vehicle inspection, Certificate of Insurance, and insurance identification cards.

vii. 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 5-40: 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 SCNs to work in coordination with entities in the region to address the social care needs of populations eligible for Enhanced HRSN Services, such as pregnant / 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.

Social Care Navigators will navigate and refer Medicaid FFS, ineligible Medicaid Managed Care Members or eligible Medicaid Members who wish to opt in to existing local, state, and federal services when the Member has at least one identified unmet HRSN in their Screening. Existing services will not receive any 1115 Waiver funding for providing their services. The Social Care Navigator will also bridge the gap for eligible Medicaid Managed Care Member's facing the ending of their HRSN service duration to ensure continuation of care. Specifically, SCNs will be required to coordinate any Enhanced HRSN Service to transition the Member to existing federal, state, and local services 60 days prior to end of Enhanced HRSN Services.

SCNs will consider existing programs and individually report on the number of Members referred to each. The SCN IT Platform's Closed Loop Referral system will allow the SCN Lead Entity to monitor and report to OHIP the connection to existing services and ensure the Member has successful accessed the existing programs for services.

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. Health Equity Regional Organization (HERO)

OHIP contracted HERO 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 HERO but are not overseen by the HERO.

iii. Proactive Member Screening outreach strategies

SCN Lead Entities 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. Member consent may be collected verbally and must be documented in the SCN IT Platform. SCNs and any entities Screening using their native EHRs must use the language below for Question 0:

<u>REVISED CONSENT TO SCREEN (QUESTION 0)</u>

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.*

If a Member is screened for unmet HRSNs using a platform other than the SCN IT Platform, Members will still need to provide consent for the sharing of Screening data (Screening Question 0) as part of the Screening in order for the SHIN-NY to share the screening data with the SCN Lead Entity to proceed with the Eligibility Assessment.

ii. Member Consent for Eligibility Assessment

Following a Screening that identifies an unmet HRSN, SCNs will conduct an Eligibility Assessment. SCNs must obtain Member consent before proceeding with an assessment. The elements of the message and the method of capturing consent are still being finalized – details will be shared at a later date. Access to social services data may require specific language, which is not yet finalized. For purposes of accessing other health records, the consent will need to minimally include a brief explanation that a Member's health data will be used in the process. Simple Member education should be provided and may be included as part of a broader consent process. For health data use purposes, approval by the Member to proceed may be provided verbally and documented.

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. Before authorizing Enhanced HRSN Services, OHIP expects that the SCN Social Care Navigator will ensure the Member is not eligible for services through other programs. For example, if a Member is already receiving mold and pest remediation services through another state program, they should not receive mold and pest remediation services from the SCN.

More information for HRSN service providers is in Section iv. *Reimbursement for services delivered by HRSN service providers in the SCN*.

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 SCN Reporting for additional details*) both before program start and on an ongoing basis. Complementing these SCN-generated reports will be a set of OHIP generated outbound reports. These outbound reports from OHIP will provide SCN Lead Entities with transparency into their performance (and peer performance) and enable continuous performance improvement.

In addition to the planned reporting, SCN Lead Entities will be expected to submit real-time updates to OHIP to enable timely assessment and management of SCN operations. The real-time updates include but are not limited to network changes, governing body changes and changes to SCN Lead Entity financials.

i. Performance Management Systems, Processes, and Validation

The SCN Lead Entity will report relevant performance metrics in accordance with detailed templates and metric definitions provided by OHIP. Select metrics and reports are detailed in this Operations Manual, and others will be outlined in additional materials provided at a later date. OHIP will review these reports to confirm accuracy and identify potential reporting issues to resolve with the SCN.

Detailed Business Requirements (DBRs) for each relevant metric – including definitions of the metric, inclusion and exclusion criteria, time ranges for reporting, etc. – will be provided to SCN Lead Entities in an instruction manual, and relevant updates will be communicated as needed to ensure accurate reporting. Reporting templates will also be provided to ensure consistent report format across all SCNs.

Inbound reports from SCN Lead Entities to OHIP will be submitted through an Excel sheet or other specified format in the Health Commerce System or other specified submission process. Outbound reports from

OHIP to SCN Lead Entities will be transmitted through email attachment or Secure File Transfer Protocol (SFTP) for the SCN Lead Entity to access.

During the initial implementation phases, there will be a need for interim aggregate-level reporting before data integration into the data lake is complete and as necessary systems, including vendor alignment, are established. Early performance management reports will focus on basic operations and network composition and then will gradually shift to include metrics focused on efficient operations, service excellence, and benchmarking across SCN entities.

OHIP will review reports to confirm their accuracy and identify potential reporting issues to resolve with the SCN Lead Entity. For selected identified metrics that are calculated by SCN Lead Entities and available to OHIP through data aggregated into OHIP's 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 support SCN Lead Entities with performance improvement should performance concerns be identified.

Further Actions on Performance Management

Based on performance management reports and discussions, OHIP may implement certain levers to support and assist the SCN, including tools for analysis, management, data analysis, and consulting.

Additionally, OHIP will establish certain benchmarks for performance management metrics. If the SCN does not meet the listed benchmarks, OHIP may provide short-term increased technical assistance to improve the metric outcome. If SCN Lead Entities have consistent issues with performance management, OHIP may require increased frequency of touchpoints between SCN Lead Entities and OHIP contract managers, and enhanced analysis of SCN data.

For any performance management issues that the SCN does not have direct control over – such as HRSN service provider operations or relationships with regional networks and other partners – OHIP may be able to provide direct outreach to help alleviate issues. For direct SCN Lead Entity performance management issues – such as internal data processing, staffing, or training / onboarding - OHIP will work directly with the SCN Lead Entity.

Select Performance Operating Report Metrics

OHIP plans to monitor performance using a set of key metrics. Below are a set of proposed key operating metrics that may be used to assess SCNs on their performance through monthly monitoring and reporting. The final list of metrics will be communicated to SCN Lead Entities by their contract manager.

Metrics marked with two asterisks (**) are metrics also calculated by the SCN Lead Entity and submitted through the 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 identified unmet HRSNs who are successfully contacted within 5 business days (%)
- Eligibility Assessment criteria response type by SNOMED/ICD10 Code (as % of screens that identify an unmet HRSN)
- 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 identified unmet HRSNs in their Screening who are navigated to existing federal state, and local programs within 7 business days (%)

Intervention / service delivery:

- **Members for 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. OHIP or their designated contractors may, at their discretion, access the SCN IT Platform to query for required metric reports that do not contain PHI or clinical level information if deemed necessary.

Table 6-1 provides a summary of reports. The final and most updated reporting templates and instructions for SCN Lead Entities will be rolled out as they are available and made accessible via a link to SCN Lead Entities.

The following sections outline details for each report, including report description and objectives; report metrics, details, and SCN implications; and submission details.

Submission process for all reports: SCN Lead Entities must submit their reports to their designated SharePoint page. The lead entity must direct any requests to add or delete SharePoint users to their assigned OHIP contract manager.

Table 6-1: Overview of major reports

Report Name	Description	Cadence
1. Quarterly Performance Report	Report will reference the progress made during the last quarter (including Work Plan Performance Measures) and includes a series of questions related to Objectives	Initial submission due on November 30, 2024; Thereafter, due 1 month after the end of each quarter: • February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)
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	February 15, 2025, and each month thereafter
3. Governing Body Report	Report detailing governing body selection and, if needed, resubmission with any updates to the contract manager	One-time initial submission due on November 30, 2024; resubmitted as needed
4. Network Composition Plan and Report	Report of network composition and quarterly reports to maintain and monitor network adequacy	Initial submission due on November 30, 2024; Thereafter, due 1 month after the end of each quarter: • February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)
5. Infrastructure Cost Report	Report containing the BSROE (Budget Statement	Initial submission due on November 30, 2024; Thereafter, due 1 month after the end of each quarter:

	Report of Expenditures) spreadsheet, including expense checklist by category and tracking the spend of infrastructure funding	• February 28 (Nov-Jan reporting period) • May 31 (Feb-Apr reporting period) • August 31 (May-July reporting period) • November 30 (Aug-Oct reporting period)
6. Budget Reassessment Report	Report of SCN re-assessment of current staffing and infrastructure needs and submission of Budget Modification, if applicable	New Year Template due by May 31, 2025, and annually thereafter. Budget Modification Template due on an as needed basis.

i. Quarterly Performance Report

Report Description and Objectives

The purpose of the Quarterly Performance Report is for SCN Lead Entities to provide a narrative report on their overall performance and relevant performance measures and tasks. The Quarterly Performance Report will contain narrative on the progress made during the last quarter (including Work Plan Performance Measures) and include a series of questions related to Objectives.

Report Metrics and Details

The Quarterly Performance Report will include SCN successes and accomplishments, as well as any obstacles the SCN has faced and the steps they have taken to overcome obstacles. Additional information will be requested for SCN Lead Entities to detail progress towards ensuring all relevant trainings are provided to SCN Lead Entity employees, HRSN service providers, etc.

Submission Details

Submission deadline of 1 month after end for each quarter (e.g., August-October, November-January, February-April, May-July). Quarterly Performance Reports will be submitted using an OHIP-provided Word template.

Table 6-2: Quarterly Performance Report required components

Report sections – subject to change per OHIP	
Category	**Component**
IT and Technology Infrastructure	• Quarterly Performance Report - Narrative • SCN IT Platform identification & functionality • Authorized user onboarding

	• 1115 SHIN-NY Interoperability Guidance[3] • Privacy, security, and compliance requirements
Network Administration, Capacity Building and Partnerships	• Narrative Progress Report Quarterly Performance Report - Narrative • Network adequacy & technology assessment • Staff hiring & onboarding • MCO contracts • Staffing / Performance Reassessments
HRSN Screening and Service Delivery	• Quarterly Performance Report - Narrative • Social care claims submission process • Medicaid Members screened
Documentation and Performance Reporting Submission	• Summary update of main report submissions and adherence / guidance to standards

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.

[3] SCN Lead Entities and their IT Platform partners can access more information at https://www.nyehealth.org/1115-waiver/ or on NYeC's NYHER 1115 Extranet

Submission Details
The submission deadline for the first Monthly Horizon Report is 2/15/2025 and the fifteenth of every month thereafter. Monthly Horizon Reports will be submitted using an OHIP-provided Excel template.

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 Governing Body 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 will indicate on their Governing Body Report which Board Member represents each awarded region.

After submitting the Initial Governing Body Report, the SCN Lead Entity will subsequently convene the governing body at routine intervals or on an ad-hoc basis.

Report Metrics and Details
The SCN Lead Entity shall initially select the governing body prior to service start date and shall include the requirements listed in Table 6-4 in their submission.

Submission Details
The submission deadline for this report is November 30, 2024, and updates are to be resubmitted as needed. Governing Body Reports will be submitted using an OHIP-provided Excel template.

This report does not need to be resubmitted to the SCN Lead Entity's contract manager unless there are significant changes to the governing body members. Any changes to the governing body may be sent to OHIP via email or letter including the change of name and title on a real-time basis (as needed).

Table 6-4: 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 o 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:
	  o 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
	  o Includes CBOs with at least one (1) service location in the SCN's region
	  o Includes at least one (1) HRSN service provider with mental health and SUD experience
	  o 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 11/30/2024 to the contract manager of the SCN Lead Entity. Moving forward, SCN Lead Entities will submit a comprehensive quarterly Network Composition Report detailing the network to assess for adequacy.

The Network Composition Plan and Report are split across relevant HRSN categories: Housing & Utilities, Food Security, Transportation, HRSN Screening & Navigation.

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 11/30/2024. The quarterly Network Composition Report submission deadline is 1 month30 days after end for each quarter (August-October, November-January, February-April, May-July) 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 • FEIN and address of HRSN service provider • NPI of HRSN service provider, if applicable • Entity types for HRSN service providers • Designation to screen by HRSN service provider • Modalities used for screening by HRSN service provider • Designation of HRSN service providers to conduct Eligibility Assessment and Navigation • HRSN service provider annual budget of less than $5 million • When HRSN service provider was added or removed from Network • If HRSN service provider has completed all required trainings • HRSN service provider interest in Infrastructure Capacity Building Funding • County or counties served by HRSN service provider • Services to be provided by HRSN service provider – screening, navigation, and/or Enhanced HRSN services •

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 CBO capacity building funding 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 CBOs (e.g., CBOs with annual budget of less than $5 million)

Submission Details

Submission deadline of 1 month after end of each quarter (August-October, November-January, February-April, May-July). Infrastructure Cost Reports will be submitted using an OHIP-provided Excel template.

Table 6-6: Infrastructure Cost Report required components.

Components – subject to change per OHIP	
BSROE Component	

Overall	• Personnel Services Detail
	  o Names, Salary, Budget & Expenditures by quarter, to date, and remaining balance, Fringe
	• Non-Personnel Services Detail
	  o 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 the New Year Budget Template will be 5/31/2025, and annually by May 31 thereafter. The Budget Modification Template will be submitted on an as needed basis. Budget Reassessment Reports will be submitted using an OHIP-provided Excel template.

Table 6-7: Budget Reassessment Report required components

Annual metrics – subject to change per OHIP	
Category	**Component**

New Year Budget Template and/or Budget Modification Template	• Personnel Services Detail
	  o Position Title
	  o Current & Proposed Amounts
	  ▪ Salary, Work Week, FTE %, Months Funded, Budgeted Amount, Fringe Benefits, Net Change
	  o Justification, Calculation, and Reason for Change

	• Non-Personnel Services Detail
	  o Contractual Services
	  o Current & Proposed Budget, Net Change
	  ▪ Contractual Services, Travel, Equipment, Space / Property Expenses Rent / Own, Utility / Operating / Other Expenses
	  o 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, 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. The primary intent of soliciting feedback is to understand satisfaction for Members receiving Enhanced HRSN Services. SCNs are strongly encouraged, but are not required to, collect feedback of Members who only received screening or navigation. 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 Complaints and Reportable Incidents

Complaints may be filed by a Member, their parent(s) or legal guardian, provider, or anyone else on behalf of the Member regarding the provision of services, activities, or benefits by the SCN program. Submitting a complaint will not jeopardize a Member's participation in the SCN program.

Table 6-8: Definitions of grievances, complaints, and reportable incidents

Term	Definition
Grievance	A wrong or hardship suffered (real or perceived), which is the grounds of a complaint
Complaint	Dissatisfaction expressed verbally or in writing by or on behalf of a Member. Complaints can include, but are not limited to:

	• Any violation of rights • Availability of service or ability to receive service • Quality of care received and/or whether services are meeting the member's needs • Afforded choice of HRSN service providers • Program eligibility and/or qualifications • Whether health and welfare are being maintained • Dissatisfaction with services or providers of services
Reportable incident	An event involving a Member, which has, or may have, an adverse effect on the life, health, or welfare of the Member

SCN Lead Entity responsibilities: SCN Lead Entities are the first point for review and resolution of incoming Member Complaints. SCN Lead Entities are expected to review and resolve Member complaints in a timely manner. OHIP acknowledges that SCNs will establish varied processes to address Member complaints; a minimum set of processes and timeliness standards are outlined below. As the first point of contact for Member complaints, SCN Lead Entities should receive all complaints related to SCN operations and service delivery, including but not limited to dissatisfaction with Screening, Navigation, and Enhanced HRSN service delivery (i.e., care management, housing, nutrition, transportation), Network capacity and access, and denial of services.

Escalation to MCO or DOH: As appropriate (e.g., the SCN Lead Entity cannot resolve the complaint on their own), SCN Lead Entities may escalate complaints to:

- **Member's MCO**: complaints related to Member eligibility for services, or
- **NYSDOH OHIP Bureau of Consumer Services (BCS)**: complaints related to plan non-compliance.

Complaints submitted directly to MCOs or OHIP: Consistent with existing MCO and OHIP processes, Members may also submit complaints directly to the Member's MCO or to OHIP. *Additional details on how Members can submit complaints directly to OHIP are forthcoming.*

OHIP may engage relevant SCN Lead Entities regarding Member complaints it receives. In the event an MCO receives a Member complaint, the Member's SCN Lead Entity will be required to provide relevant information to the MCO to address the complaint. MCOs should following existing MCO approaches and guidelines for SCN program Member complaint review, resolution, and reporting to DOH.
In order to help ensure the SCN program addresses the needs of Members, OHIP expects SCN Lead Entities to report complaints to OHIP in summary form on a quarterly basis.

Member complaint process

Expectations regarding informing Members of complaint processes:

During the Eligibility Assessment, Navigators are required to verbally inform Members how they may submit complaints to an SCN Lead Entity. SCN Lead Entities should ensure that options for Members to submit complaints are varied and accessible and that Members may submit complaints at any time.

SCN process to resolve Member complaints:

Development of SCN Lead Entity plan for resolving Member complaints

OHIP expects that SCNs establish processes related to the review and resolution of complaints. These processes should include at a minimum:

- Process for how SCNs receive and review complaints
- Requirements for documenting receipt of a Member's complaint (e.g., name, address, phone number of complainant and location, date, and description of the complaint)
- Guidance for documenting the resolution of Member complaints in the Member's Social Care Plan (if relevant)
- Resolution steps that will be taken to address a complaint, including but not limited to:
    - Reviewing the details of the complaint
    - Meeting 1:1 with the Member regarding their complaint
    - Sharing the resolution with the Member
    - Process to ensure that if a Member is not satisfied with the resolution, the SCN must refer the Member to their MCO

OHIP requirements related to complaints

OHIP wants to ensure that Members receive timely resolution for any complaints submitted to SCNs. SCNs must meet the following standards related to complaint resolution:

- **Contacting and updating the Member within 72 hours of receiving complaint**
- **Responding and resolving within 45 calendar days of receipt of the complaint**

SCNs should report to OHIP a summary of Member complaints on a quarterly basis. *Additional details on this reporting are forthcoming, including an OHIP-provided report template for SCN Lead Entities to report a summary of Member complaints.*

Member reportable incidents process

In the event a Member experiences a reportable incident, SCNs must take additional steps beyond the standard complaints process that account for the Member's adverse experience to reach a resolution. SCN Lead Entities should ensure processes are in place such that the Network can meet the following timing requirements with regards to reportable incidents.

- The entity receiving a reportable incidence (e.g., Social Care Navigator or HRSN service provider) must inform the SCN Lead Entity of a reportable incident within 24 hours of notification or discovery

- The SCN Lead Entity must inform OHIP of the reportable incident within 24 hours of being informed about the reportable incident via email to SDH@health.ny.gov
    - In sharing the reportable incident with OHIP, SCN Lead Entities should include in the subject line “Reportable incident”.

OHIP will review the reportable incident submitted by the SCN Lead Entity and work in collaboration with the SCN Lead Entity to resolve and communicate the resolution to relevant stakeholders, including the Member, HRSN service provider, etc.

7. PAYMENTS

Payments subsections:

a. Infrastructure funding

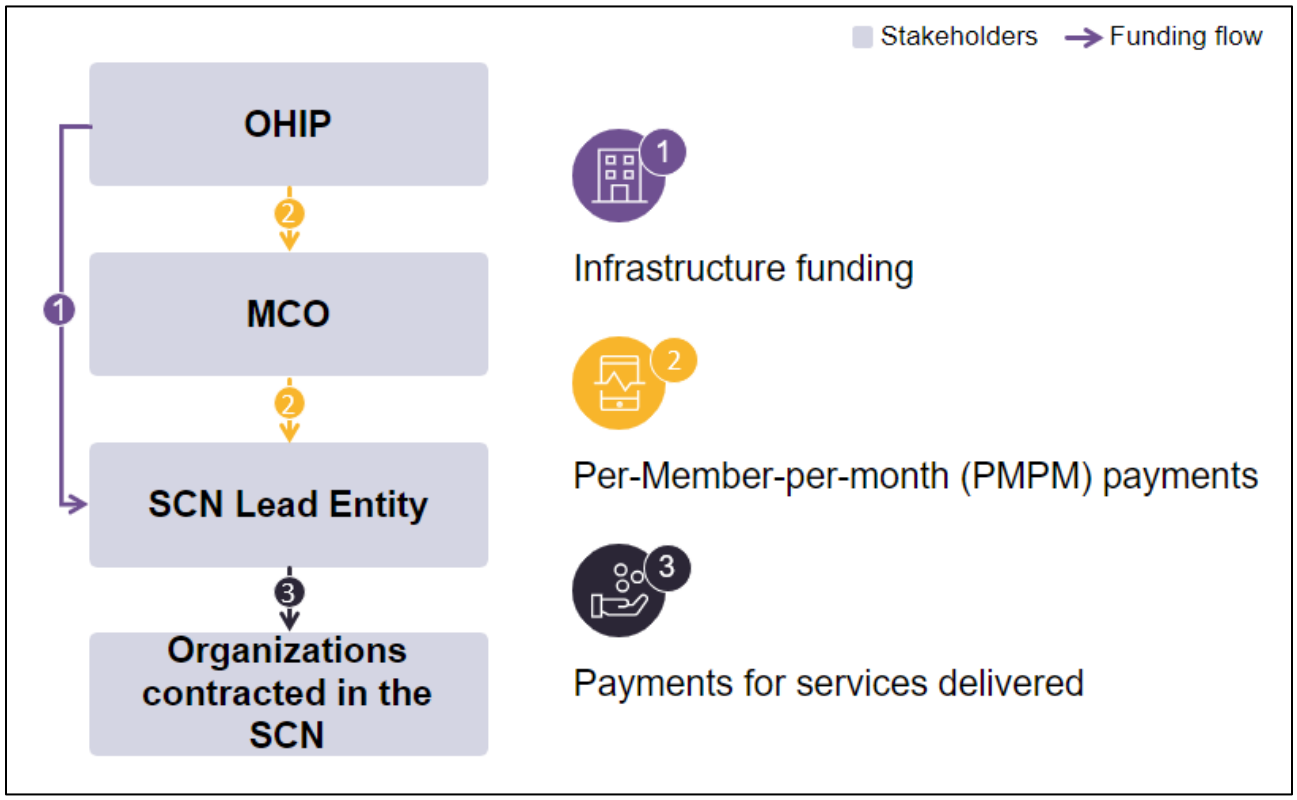
b. PMPM payments

c. Payment methodology for services delivered

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 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. The MCO will make the PMPM payment to the SCN by the 15th of each month.
3. *FFS payments for screening and HRSN services:* SCN Lead Entities will pay for Screening, Navigation, and Enhanced HRSN Services delivered according to a set HRSN fee schedule.

Figure 7-1: Overview of payment flows included in SCN program



For the Medicaid FFS population, the SCN Lead Entity will directly bill eMedNY for Screening and Navigation for the region's Medicaid FFS population. The SCN Lead Entity will use the PMPM Payment to provide the Network with payments for Screening, Navigation, and Enhanced HRSN Services for the Medicaid Managed Care population.

After the 1115 Waiver period, a subsequent payment mechanism may be established and is beyond the scope of the current program. SCNs may continue to receive funding from state, federal, or private grants during and after the initial three-year contract period.

The following section provides an overview of each type of payment within the 1115 Waiver, including funding amount and mechanics details, uses of funding, and funding requirements.

1) INFRASTRUCTURE FUNDING

▪ Funding amount and mechanics

To ensure that SCNs are able to build capacity and capabilities, OHIP is providing up to $500 million in federal infrastructure funding for the operational setup of the program across the three-year RFA period. SCN Lead Entities may use infrastructure funding to build necessary functionality and capabilities across the Network, either through direct use of funds for activities impacting capabilities of the Network, or via capacity building grants provided to CBOs.

The maximum infrastructure funding available for each SCN varies by region and is based on the number of Medicaid Members and cost of delivering HRSN services in its region. OHIP has communicated to each SCN Lead Entity the maximum funding amount available in each year. SCN Lead Entities are required to keep receipts, records and other financial documents related to the federal infrastructure funding for the balance of each calendar year in which they were made and for six (6) additional years thereafter.

While OHIP's goal is to ensure that all SCNs 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. The 25% advance funding is subject to recoupment every quarter.

SCN Lead Entities will receive the majority of their infrastructure funding beyond the advance retrospectively after the milestones and targets are reached and reports are submitted.

▪ 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 may rollover unspent funds from quarter to quarter, subject to the spending minimum detailed below.

OHIP will collect the SCN Lead Entities' estimated infrastructure budget proposal for each year based on the Annual Infrastructure Reassessment Report and will require SCN Lead Entities to report their expenditures on a quarterly basis.

Table 7-1: Allowable uses of infrastructure funding and eligible organizations

Infrastructure funding category	Use of funds	Mechanism for SCN Lead Entity or other entity to use funds
SCN Lead Entity core staff costs	• Cover salaries for key SCN staff members working directly on the program (e.g., program director, Navigators)	• Funding used directly by SCN Lead Entities • SCN Lead Entities may use funding to hire Navigators at other entities in the Network
SCN Lead Entity administrative / indirect costs	• Cover indirect operating expenses (e.g., back-office staff, physical office space, legal fees, etc.)	• Funding used directly by SCN Lead Entities
IT Platform and Systems costs	• Support entities contracted into the SCN to onboard onto the SCN IT Platform (e.g., vendor or user licenses) • Build technical capabilities of entities contracted into the Network (e.g., additional training not provided by IT vendors)	• SCN Lead Entities may use funds to support any organization contracted in the Network, including CBOs, FQHCs, Health Systems, Health Homes, care management agencies, etc.
Capacity building funding for CBOs	• Build capabilities (e.g., hiring staff members) and program functionality (e.g., provide training for staff, purchase equipment, rent office space) of CBOs contracted into the Network to deliver Enhanced HRSN Services	• SCN Lead Entities provide funding to CBOs. These organizations must be not-for-profit charitable organizations that work at the local level to meet community needs and provide Enhanced HRSN Services directly to Members. • Health systems (as defined in this manual), MCOs, FQHCs, care management agencies, local departments of health, health homes, and for–profit entities are NOT eligible to receive this grant funding

▪ Funding requirements

Each quarterly payment will be split into portions tied to reporting requirements, implementation milestone requirements, and performance requirements. If an SCN fails to meet any of these requirements in a given quarter, it will not receive the funding tied to that requirement for that quarter. The funding amounts tied to each requirement type in each quarter are shown in *Table 7-2*.

Table 7-2: Breakdown of infrastructure funding amounts tied to reporting, implementation milestones, and performance

Type of requirement	Performance/Contract Year 1 (8/1/2024 – 7/31/2025)	Performance/Contract Year 2 (8/1/2025 – 7/31/2026)	Performance/Contract Year 3 (8/1/2026 – 3/31/2027)
Reporting	90% of infrastructure funding	85% of infrastructure funding	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. If an SCN Lead Entity does not reach the threshold in a given quarter, the SCN Lead Entity may only receive additional funds in a subsequent quarter (after the 70% threshold is met). For example, an SCN will be 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

Implmentation Milestone	Deadline (subject to change)
Data and IT Platform identified	9/1/2024
Contracts in place with MCOs	10/18/2024
Competency with HL7 FHIR national standards	10/31/2024
SCN-QE Addendum to the Participation Agreement	11/1/2024
Medicaid Critical Controls Attestation and System Overview Document	Draft: 11/22/2024 Final: 12/15/2024
1115 SHIN-NY Interoperability Established	1/1/2025
100% of HRSN service providers that have contracted into the Network are onboarded onto the SCN IT platform	12/31/2024
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 identified unmet HRSNs who are successfully contacted within 5 business days (%)
- Members referred within 7 business days (%)
- Referrals made that are accepted within 5 business days (%) (Year 3 only)
- Closed Loop Referral rate (% of Referrals)

After collecting baseline performance data, NYS will communicate additional details on the specific targets SCNs will need to meet for each metric in each quarter. To receive infrastructure payments tied to performance in a given quarter, SCNs must achieve all the performance targets set for that quarter. OHIP will not make partial payment to SCNs that achieve some performance targets but not others.

2) 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:

i. OHIP will provide regional 1115 Waiver funding directly to MCOs for the purpose of distributing PMPM payments to the SCN Lead Entities (MCOs will bill eMedNY for the PMPM on a monthly basis)
ii. The MCO will then allocate a PMPM payment to each regional SCN Lead Entity by the 15th of every month
iii. SCN Lead Entities will provide social care claims to all contracted MCOs for Enhanced HRSN Services provided to Members within the Network
    a. The service amount submitted on the social care claim will be based on each SCN's HRSN fee schedule approved by OHIP
    b. 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 or provide feedback on the reconciliation results.. In the event that the MCO or SCN contests the results, the MCO, SCN, and OHIP will commence 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, 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, 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 based on the HRSN fee schedule for Screening, Navigation, and Enhanced HRSN Service Delivery for MMC Members.

SCN Lead Entities are expected to reimburse contracted organizations in their Network for all approved services delivered, including for one annual HRSN Screening per Member (unless a Member is eligible for re-screening due to a Major Life Event).

SCN Lead Entities may use a maximum of 3% of PMPM funds they receive for ongoing administrative and operational costs incurred for HRSN service delivery (e.g., claims processing, performance management). The remaining 97% of PMPM funds sent to SCN Lead Entities may be used to cover service delivery (e.g., Screening, Navigation, delivery of Enhanced HRSN services) or to accrue for annual reconciliation.

The administrative 3% is not subject to recoupment except when it has been paid as the result of an inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake. The administrative 3% will not be part of the reconciliation process.

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 Lead Entity is expected to automate the process for submitting Social Care Claims to MCOs. Social Care Claims for Enhanced HRSN Services must be sent to MCOs via Electronic Data Interchange (EDI) 837 file format. The SCN Lead Entity must submit all claims to MCOs via the SCN IT Platform within 90 days from payment date.

Tracking and receiving Social Care Claims:

- After the HRSN service provider has indicated in the SCN IT Platform that a service has been completed, the SCN Lead Entity will submit the Social Care Claim to the MCO through the SCN IT Platform in the EDI 837 file format
- The MCO will accept and intake accurate claims and send back to the SCN Lead Entity an 835 remittance
- SCN Social Care Claims for Enhanced HRSN Services will be linked to MCO claims and reported Encounter data to support the tracking of outcomes
- After the service is delivered, the MCO must collect and retain claims submitted by the SCN for a minimum of ten years per federal requirements

c. PAYMENT METHODOLOGY FOR SERVICES DELIVERED

(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 each SCN's HRSN fee schedule approved by OHIP.

The HRSN fee schedule includes guidance on how services should be delivered to receive reimbursement, and where relevant, maximum allowable units and frequency for specific services. Rate types vary by service, and include:

- Rates: Specific rate for the delivery of a service
- Ranges: A rate range (high/low end) that will give SCNs flexibility to set rates for different scopes of services delivered. For services for which OHIP has provided a range, SCNs are expected to manage expenditures by setting rates based on individual Member needs (i.e., services should fall into the upper portion of the range only in limited circumstances)
- Per Member cap: A maximum amount that can be spent on a particular service category that provides SCNs with flexibility on the best way to address a Member's needs as it relates to that service

In the context of the 1115 Waiver, CMS has established annual program-level caps for funding for MMC Members across three HRSN service categories: CTS Broker's Fee, cooking supplies, and transportation services. For each of these three HRSN services with caps, OHIP will define SCN-level annual caps that take into account Member needs in each region. OHIP has defined SCN-level caps for Year 1 (January 1, 2025 - March 30, 2026) based on the Enhanced population in each SCN region and costs to deliver services in each region (for transportation). OHIP will determine new SCN-level caps for Year 2, and may base new caps on demand for services across each region as information becomes available during the program.

Each SCN Lead Entity is responsible for managing spend for their region and ensuring services do not exceed the defined cap, as provided in each SCN's HRSN fee schedule.

ii. Uses of funding

SCN Lead Entities are responsible for payment of services for two different types of Members:

1) *Medicaid Managed Care Members (PMPM payments)*
    - Payments will flow from the SCN Lead Entity to HRSN Service providers based on the HRSN fee schedule approved by OHIP. SCN Lead Entities must be designated as official Medicaid billing social care provider entities and must process claims and payment on behalf of the contracted organizations in their network for delivering Screening, Navigation, and Enhanced HRSN Services.

- The SCN Lead Entity will provide HRSN fee schedule-based reimbursement payments to contracted HRSN service providers within 30 days after an accurate invoice for service delivery is generated in the SCN IT Platform. For home remediation services, reimbursement should be provided by the date specified in the contracted provider's invoice. The SCN Lead Entity must submit all claims to the MCO within ninety (90) days from payment date.
- Payments to the HRSN service providers should be made on at least a monthly basis for services provided on an ongoing, regular cadence that span over multiple months
- Program-level funding caps for select 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.
- The SCN Lead Entity must submit all claims to MCOs via the SCN IT Platform within 90 days from payment date

2) *Medicaid FFS population (eMedNY FFS Billing)*
   - OHIP will reimburse the SCN Lead Entity for the Medicaid FFS population upon a submitted claim
   - Each regional SCN Lead Entity will have direct access to bill eMedNY for Screening and Navigation associated to the region's Medicaid FFS population
   - SCN Lead Entities should bill eMedNY directly for services completed within the Medicaid FFS population for Screening and Navigation based on the regional HRSN fee schedule, billing, and service codes provided by OHIP
   - The SCN Lead Entity in turn, will submit the rendered Medicaid FFS claim through eMedNY with their corresponding MMIS# and NPI number, HRSN service data and if applicable, the CBO's EIN, TIN, or NPI
   - OHIP will monitor Medicaid FFS claims within eMedNY as needed. The SCN is not required to submit a report to support eMedNY claims
   - The SCN Lead Entity must submit claims to eMedNY within 90 days of service delivery.

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).

iv. Reimbursement for services delivered by HRSN service providers in the SCN

HRSN service providers within the SCN may be receiving funding from other sources to provide HRSN services to Medicaid Members (e.g., via block grants). For all individuals that meet the below criteria, HRSN service providers may bill and be reimbursed for services delivered in accordance with the regional fee schedule established by the SCN Lead Entity.

HRSN service providers may be paid for screening and services delivered if:

- They are contracted with the SCN Lead Entity
- For HRSN services, Member was referred to the HRSN service provider through the SCN referral pathway (by a Social Care Navigator using the SCN IT Platform)
    - If the Member was referred through an alternative pathway outside of the SCN (e.g., through an existing grant program), the provider cannot bill for the services delivered to the SCN and should use existing funding. If the service provider thinks the Member is eligible for appropriate enhanced HRSN services, the service provider can direct the Member to the SCN Lead Entity to get a referral.
- Member is eligible for the HRSN service as determined by the SCN program; for enhanced HRSN services, eligibility requires Members to be enrolled in Medicaid Managed Care, meet specific enhanced population and clinical criteria, and demonstrate unmet health-related social needs determined by the SCN program
- Services delivered are among the services approved by the SCN program (see https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm)
- HRSN service provider follows any additional agreed upon terms as outlined in contracts with SCN Lead Entities

HRSN service providers are encouraged to use multiple funding sources (braided funding) to holistically address Member needs. The 1115 waiver funding for HRSN services may not replace funding from other local, state, or federal programs. When applicable, this funding should be used to support the allowable HRSN services that the Member cannot access through other programs. Braided funding consists of multiple funding sources that are initially separate but, brought together to pay for more than any one funding source can support, and then carefully pulled back apart to report to funders on how the money was spent. For example, a Medicaid member can receive housing navigation under a grant program and then be referred to the SCN to receive community transition service paid through the waiver. Services provided to a Member that are outside the scope of New York Health Equity Reform (NYHER) cannot be reimbursed regardless of whether a Member is concurrently receiving SCN-referred services.

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

o 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.

o 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 (COI) Plan

To ensure that SCNs operate in the Member's best interests, each SCN Lead Entity should establish COI considerations for their Network. Each SCN Lead Entity is required to create a COI Plan, detailing how their Network will maintain COI for the duration of the SCN Program. Each SCN's COI Plan is due to OHIP on November 30, 2024 for OHIP review and approval.

OHIP requires the following components of the COI plan to be included in each SCN Lead Entity's Plan:

1. **Ensure Social Care Navigators are not related to the Member**, their paid caregivers, or anyone financially responsible for the Member
2. **Ensure program eligibility determination and Navigation are separated from Enhanced HRSN Service delivery,** including:
    - **What safeguards and firewalls will be in place to mitigate risk** of potential conflict in circumstances where one entity is responsible for both Navigation and Enhanced HRSN Service delivery
    - **What safeguards will be in place to ensure that dwelling assessments and SOW development is independent of Enhanced HRSN Service delivery** for Home Accessibility and Safety Modifications, Home Remediation Services, and Asthma Remediation
    - How the SCN will **disclose an organization's dual relationship to Members** in the event one entity is responsible for both Navigation and Enhanced HRSN Service delivery

3. **Monitor and oversee** potential COI
    - Monitor the **prevalence of internal referrals**
    - Monitor the **prevalence of referrals between organizations with relationships** beyond the SCN program
4. **Enforce the COI plan** across the Network

    Periodically re-evaluate its safeguards and firewalls

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.

iii. Enhanced Services Member File

An Enhanced Services Member File, which includes all MMC plan Members, will be referenced during the Eligibility Assessment to identify all Members who reside in the SCN's region and detail their eligibility information. (*For more information, see Enhanced Services Member File)*

iv. PMPM Payments

The purpose of the PMPM payment methodology is to ready the MCOs and SCNs to participate in VBP arrangements after year 3 of the demonstration period. After year 3, when VBP arrangements begin, the payment structure will remain, assumption of risk will begin, and the methodology will be embedded into the Managed Care Model Contract.

(*For additional information on PMPM policies / procedures, see MCO-SCN Agreement Template and Operations Manual Payments section*)

v. MCO SCN IT Platform Training

The SCN Lead Entity must onboard, train, and support MCOs who elect to use the SCN's IT 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. The SCN Lead Entity can utilize the Office of the Medicaid Inspector General's (OMIG) website to confirm Medicaid Good Standing: Search Exclusions (ny.gov)
   - HRSN service providers do not have to be Medicaid billing social care providers to join the SCN and this instance only applies to HRSN service providers conducting Medicaid services outside of the SCN Lead Entity's scope as a Tier 2 or Tier 3 CBO

- Contracts with HRSN service 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;
   - HRSN Service Providers or CBOs are allowed to bill for HRSN Services rendered at the same address as a licensed clinic site under Article 28, 31 or 32 (including those funded by local departments of health).;
   - Requirement to maintain coverage areas that includes zip codes within the SCN Lead Entity region;
   - Designate contact(s) in their organization to engage and be trained on the SCN IT Platform and validate the accuracy of HRSN service provider information at routine intervals;
   - Be willing and able to receive training(s) on screening Members for HRSN with cultural and linguistic competency;

3. Using the SCN IT Platform: HRSN service providers that are accepting Referrals are required to be onboarded to the SCN IT Platform, with training support from the SCN Lead Entity. HRSN service providers are expected to have capability to operate within the SCN IT Platform and comply with all data requirements for Screening, Navigation, and Enhanced HRSN Service Delivery as needed

4. CBO Capacity Building: CBOs will be allocated infrastructure funding intended to support capacity building across the Network. Use of funds for capacity building can include, but is not limited to, hiring staff members, enrolling in the SCN IT Platform, or providing training across the organization

5. HRSN service provider subcontracting: The contract between the HRSN service provider and the SCN Lead Entity should have specifications for any subcontracting relationship and how that relationship is managed within the SCN IT Platform and for payment

ii. For-Profit entities:

SCN Lead Entities must contract and place preference upon using non-profit entities for Enhanced HRSN Services to ensure that small non-profits that are embedded in the communities being served are able to participate in the SCN. However, SCN Lead Entities are permitted to contract with for-profit organizations that are within their region to provide Screening, Navigation, and Enhanced HRSN Service Delivery. SCNs are expected to communicate to OHIP the rationale for inclusion of 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;

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

v. 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 those services have not been reimbursed by Medicaid fee-for-service, Medicaid Managed Care, or a third-party payer. Screening, Navigation, and Enhanced HRSN Services provided on the same day as a threshold visit are not considered covered under Medicaid FQHC PPS reimbursement and remain eligible for separate SCN reimbursement.

Additionally, FQHCs should not report visits and revenue associated with SCN services on the Managed Care Visit and Revenue (MCVR) report as these services are not eligible for the Supplemental Payment Program. Medicaid PPS threshold visits remain eligible for the Supplemental Payment Program, further distinguishing these services from SCN reimbursements. Visits and revenue associated with SCN services should not count towards participation in federal programs.

Certified Community Behavioral Health Centers (CCBHCs) can be reimbursed for HRSN Screening if they are not reimbursed by Medicaid FFS, MMC, or a third-party payer for those services.

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.

vi. Health Homes (HH)

SCNs are strongly encouraged to contract with all Health Homes (HHs) in their region. HHs that are contracted to participate with the SCN Lead Entity may provide Screening, Navigation and Enhanced HRSN Services. Health Homes that do not wish to join the SCN are encouraged to direct Members to the SCN for Screening, Navigation, and services not offered through the HH. References to HHs in this section refer to the HH organization in its entirety, including any subcontracted entities within the HH. HHs can start to receive payment for services delivered through the SCN Program (e.g., Screening, Navigation, Enhanced HRSN services) as of 1/1/2025.

One contract between an SCN Lead Entity and a Health Home may apply to and cover all Care Management Agencies (CMAs) that are part of the HH for Screening and Navigation. CMAs that perform functions in addition to Screening and Navigation (e.g., Enhanced HRSN services such as pantry stocking, MTMs) will need to contract directly with the SCN Lead Entity.

Health Homes that are part of an SCN or serving as an SCN Lead Entity

Screening:

- HHs that are a part of an SCN should screen Members for HRSNs. Given that HHs already conduct HRSN screening as part of the HH comprehensive assessment, HHs may:
    - Add additional questions to their existing screening process (e.g., education and employment)
    - Create a separate screening process within the SCN IT Platform

- HHs can start to receive payment for Screening by 1/1/2025 for any Screenings consistent with requirements for requirements (see Screening Methodology section for requirements for reimbursement)

Navigation:

- HHs contracted into the SCN can conduct Navigation for both Members of the HH and Members outside of the HH
- For existing HH Members, HHs may include social care goals from the existing care plan in the SCN Social Care Plan to reduce duplication in care planning activities
- For new HHs Members without existing care plans, Health Homes may decide to distribute goals across care plans (e.g., clinical goals in Health Home care plan and social care goals in SCN Social Care Plan)

HHs that are contracted within the SCN will be reimbursed for:

- Screening consistent with requirements for reimbursement (see *Screening Methodology* section for requirements for reimbursement)
- Navigation to Enhanced HRSN Services for Members that are eligible as determined by a Social Care Navigator during the Eligibility Assessment, including:
    - Conducting an Eligibility Assessment in SCN IT platform
    - Creation of a Social Care Plan for Members in the SCN IT Platform
    - Referral of Members to Enhanced HRSN Services in the SCN IT Platform
    - Ongoing engagement with Members related to Enhanced HRSN Service Delivery
    - Referral closure in the SCN IT Platform

HHs that are contracted within the SCN will NOT be reimbursed for:

- Navigation to existing federal, state, and local services (given this service is already being provided by HHs) for Members that are NOT eligible for Enhanced HRSN services from the SCN program

Health Homes that are NOT part of SCN

HHs that are NOT in the SCN will NOT be reimbursed for any Screening, Navigation, or HRSN services.

HHs that are not part of an SCN will not receive waiver funding to establish a two-way data exchange with the SHIN-NY via QEs. HHs are encouraged to contract with QEs to upload screening data that can be shared into the SHIN-NY data lake.

HH specific questions outside of partnership with the SCN should be sent to: healthhome@health.ny.gov.

vii. 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 the Medicaid Eligibility Files and monthly Enhanced Services Member Files (see Agreement 3 below)

QE / SCN NYHER Addendum to QE Participation Agreement

The NYHER Addendum is an OHIP-approved Addendum that all SCNs will sign with its partner QE(s). Each SCN and QE will have a Participation Agreement in place, which may be unique to each QE. However, the Addendum (sets forth the terms and conditions under which certain data contributed to and received from the SHIN-NY may be accessed) 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 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. As soon as possible or by the end of the third year (Year-3) at the latest following the initiation of the contract with OHIP, all systems (on-prem, cloud, or vendor) within the SCN environment that are used to access, transmit, store, or process Medicaid Confidential Data (MCD) must achieve HITRUST® Certification as a key component of its data stewardship and oversight program. HITRUST® certification is not required from SCN's organizational level.

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		
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.)	by 9/30/2024
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 Report	All systems (on-prem, cloud, or vendor) within the SCN Lead Entity's environment who have not obtained HITRUST with the OHIP Regulatory Factor certification, must submit a copy of the assessment report to the Security and Privacy Bureau.	by 9/30/2024
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 national HL7 FHIR data standards	The SCN Lead Entity SCN IT Platform vendors shall initiate testing using HL7 FHIR national standards following the 1115 Waiver FHIR Implementation Guide recognized by OHIP. LEs must initiate testing of screening, assessment and referral FHIR bundles. Screenings must contain the consent resource, and referrals must include closed loop referral tests.	Competency with FHIR data exchange deadline of **10/31/2024.** Considered complete once SCN Lead Entity *initiates testing of valid JSONs* by 10/31/24. QEs will validate the FHIR JSONs.

SCN-QE Addendum to the Participation Agreement (formerly: SHIN-NY PA)	The SCN Lead Entity shall ensure Participation Agreement Addendums are in place with the QE.	11/1/2024
Medicaid Critical Controls Attestation and System Overview Document	SCN Lead Entities must complete and submit to the Security and Privacy Bureau at doh.sm.Medicaid.Data.Exchange@health.ny.gov and SDH@health.ny.gov	By 11/22/24, SCNs must submit the Medicaid Critical Controls Attestation and System Overview Document
Sign DOH Data Use Agreement (DUA)	SCN Lead Entities must sign the Medicaid DUA	By 11/15/2024
SHIN-NY Interoperability Established	Required interoperability with SHIN-NY. Initiating testing with SCN and QE in QA Environments includes bi-directional data exchange with the SCN's partner QE to 1) receive MEF; 2) receive ESMF; 3) receive screening data extract (flat file and/or FHIR); and 4) send all HRSN data types through partner QE. (*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*)	Initiate testing with SCN and QE in QA environments by 10/31/24. Production connectivity at the time the SCN Lead Entities start delivering services. Proven complete once SCN Lead Entity demonstrates proficiency with bi-directional data exchange for #s 1-4 (see High Level Detail) on or before *1/1/25.*
All Privacy / security / compliance requirements		
YEAR 2		
Annual Privacy and Security Risk Assessment	All systems within the SCN environment used to access, transmit, store or process Medicaid Confidential Data (MCD) that are 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		
YEAR 3		
HITRUST Certification	All systems within the SCN environment used to store, process, analyze, or transmit Medicaid Confidential Data (MCD) that are not HITRUST® certified will need to become certified by Year 3	1/1/2027

iii. Current State Security 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.

HIPAA Compliance Assessment Report

All systems (on-prem, cloud, or vendor) within the SCN Lead Entity's environment who have not obtained HITRUST with the OHIP Regulatory Factor certification, must submit a copy of the assessment report to the Security and Privacy Bureau. The report should be a document on company letterhead that states that the organization has conducted a HIPAA compliance assessment and materially complies with the requirements of the HIPAA privacy and security rules. This document should be signed by an executive authorized to legally bind the organization to legal agreements.

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 9/30/2024.

SCNs must implement role-based access standards to ensure that only authorized individuals, based on their job functions and relationship with the Member, can access PHI including but not limited to:

- **Authorization:** Authorized users must be assigned unique usernames and passwords, with strict controls on password strength, sharing, and periodic changes. Access to PHI must be limited to the minimum necessary information required for the intended purpose.
- **Role-based access control:** SCN IT Platform will support differential views by user access type (e.g., SCN Lead Entity may choose to have performance data, Member information, etc. only visible to certain users)
    - Allow specific users to view latest and historical screening status and screening results, based on ability to receive pushed extracts, and pull historical data by querying QE portal
    - Allow specific users to view and update screening results

SCNs and participants must authenticate the identity of authorized users before granting access to PHI, utilizing methods that meet the standards outlined in NIST Special Publication 800-63.

- **Authentication:** SCN Lead Entity staff will have assigned and authenticated users. SCN Lead Entities will authenticate SCN IT Platform users only if users have completed required training in the 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 create the content for and conduct periodic audits of each of their network participants to monitor use of the SCN IT Platform, their Authorized Users, and ensure compliance with the Policies and Procedures and all applicable laws, rules, and regulations.

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. Prohibited Uses: The following uses of SCN Data are prohibited:

- The sale of individually identifiable information (including but not limited to PHI and PII);
- The use of individually identifiable information for marketing purposes that would require an authorization under 45 C.F.R. § 164.508(a)(3); and
- Any purpose prohibited by applicable law.

x. 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.**

xi. 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 9/30/24.

The SCN Lead Entity is required as per HIPAA to assess their own compliance, and at this time a compliance assessment does not need to be provided to OHIP. For necessary security documentation, see ***Cybersecurity*** for more information on the Medicaid Critical Controls Attestation.

State Regulations

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

1. Amends Title 300 -SHIN-NY to reforming the structure of the SHIN-NY including emphasizing the aggregation of data to support SCN Lead Entity reporting to Medicaid via the SHIN-NY. (Adopted 6/20/2024). For additional information see: DOS, 2024. State Register XLVI (28). Albany (NY): New York State Department of State.
2. Amends Section 504.9 of the social services regulation to allow claims data to flow via the SHIN-NY and to be released with consent (Released for public comment on 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.

xii. 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.

xiii. 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://shinny.org/us/ny/hrsn/index.html.

- SCN Lead Entities may share data with QEs and other stakeholders in other standardized formats (e.g., JSON flat file, Excel file) while they work towards implementing HL7 FHIR standards.
- SCN Lead Entities will be expected to be capable of transmitting data to the SHIN-NY data lake using FHIR-based data exchange standards and adhering to the FHIR Implementation guide found here https://shinny.org/us/ny/hrsn/index.html
- Once the SCN Lead Entity contract is executed, SCN Lead Entities have until they start delivering services to connect their SCN IT Platforms with a QE

ii. QE Connectivity

SCN Lead Entities will need to partner with a Qualified Entity to send HRSN data to The Statewide Health Information Network for New York (SHIN-NY) Data Lake. If SCN Lead Entities are not yet connected with a QE, please visit “How to Connect & Use the SHIN-NY" at https://www.nyehealth.org/shin-ny/connect-use/. From here, SCN Lead Entities can navigate to each QE’s homepage. SCN Lead Entities and their IT Platform partners can access this information at https://www.nyehealth.org/1115-waiver/

iii. 1115 SHIN-NY Interoperability

SCN Lead Entities must establish interoperability by the time they start delivering services. For those already connected to a QE, HRSN data can be sent as early as **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://shinny.org/us/ny/hrsn/index.html and New York eHealth Collaborative’s website

https://www.nyehealth.org/1115-waiver/. Access to a terminology repository, validation rules, and other interoperability standards will be available in this FHIR IG and on the NYeC website. This will capture the data terminology and exchange standards as outlined throughout this Requirements Document.

Please note that certain resources are not publicly available, but NYeC is able to provide access to SCN Lead Entity staff, as well as SCN IT partners. If SCN Lead Entities or SCN IT partners are not able to open a document on NYeC's 1115 website, please contact 1115-waiver@nyehealth.org to request access. New York eHealth Collaborative will be hosting an 1115 SHIN- NY Interoperability Workgroup to solicit feedback and review content.

e. DATA SETS, TERMINOLOGIES, AND CODING

i. Introduction

To enhance communication and coordination, streamline data collection and analysis, facilitate billing processes, support research and policy development, and ensure compliance with legal and regulatory requirements, OHIP has chosen to use coded terminologies to map social care activities to HRSNs. This approach will improve the efficiency and effectiveness of services provided.

In addition to terminology standards, OHIP has developed a minimum viable dataset (MVD), that will be utilized to ensure specific data elements needed for Medicaid capture, analysis and CMS reporting are being sent by the organizations involved in the 1115 Waiver. The MVD will include Member and organization attributes needed during each HRSN data step as well as data elements that should be contributed for screenings, assessments, and referrals.

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 on NYeC's NYHER 1115 Extranet. Please make sure SCN technical teams have access. If you do not, please reach out to rwagers@nyehealth.org.

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[4] (Systematized Nomenclature of Medicine – Clinical Terms)

Provides codes, terms, synonyms, and definitions used in clinical documentation and reporting for conditions, health concern, problem, diagnosis, assessment, goal, reason for service request, or procedure.

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:** HCPCS **Managed Care:** HCPCS + State Defined Modifiers
Eligibility Assessment	SNOMED CT & ICD-10 (Z Codes)	See "Service Navigation / Care Management"
Person-Centered Goals	SNOMED CT	N/A
Service Navigation / Care Management	SNOMED CT	**FFS:** HCPCS **Managed Care:** HCPCS + State Defined Modifiers

4 This material includes content from the US Edition to SNOMED CT, which is developed and maintained by the U.S. National Library of Medicine and is available to authorized UMLS Metathesaurus Licensees from the UTS Downloads site at https://uts.nlm.nih.gov.

HRSN Referral	SNOMED CT	N/A
HRSN Service Provision + Claims / Remittance	SNOMED CT	**Managed Care:** HCPCS + State-Defined Modifiers, Rate CD (Medical Respite)

OHIP will use separate codes to identify and keep track of 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 on NYeC's NYHER 1115 Extranet. 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.

Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website for access to the live document on NYeC's NYHER 1115 Extranet.

NYHER Social Care Coding: This document is a vertically oriented version of the Screening to Services Mapper document. It is also a comprehensive view of nationally validated, standardized NYHER social care codes to utilize throughout the NYHER member journey from the Screening activity to the Services activity. This document excludes the associated HRSN billing codes. It is organized by NYHER activity type (Screening, Assessment, Goals, Navigation, Referral, Services). This document will be updated as a subset of SNOMED codes are published (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 on NYeC's NYHER 1115 Extranet.

ii. Screening for Social Risks: LOINC Codes

The SCN IT Platform will be used for screening. It must have the capability to map each individual question from the AHC HRSN Screening Tool and response with a corresponding LOINC code. This ensures Q/A pairs are properly categorized, organized, and accessed for retrieval from the QEs via the SHIN-NY Data Lake.

Screening Question and Response LOINC Codes are used for documenting HRSN screening question and answer pairs.

Table 9-3: AHC HRSN Screening Tool[5] LOINC codes[6, 7]

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
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	96779-4	**Yes**	LA33-6
		No	LA32-8
		Already shut off	LA32002-0
	88122-7	**Often true**	LA28397-0

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

QUESTION	QUESTION_CODE	ANSWER_VALUE	ANSWER_CODE
4. Within the past 12 months, you worried that your food would run out before you got money to buy more		**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
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)

A Member can elect to skip screening questions or a Navigator can make the decision not to ask certain questions at their own discretion; however it is required that a response per the below options is populated. 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)

It is required that answers to all questions are answered (with the exception of interpersonal safety) or a Member will not be able to submit the screening.

iii. Eligibility Assessment ICD-10 / SNOMED-CT Coding

All positive AHC HRSN Screening Tool responses will require further Eligibility Assessment. The coding required during the Eligibility Assessment can only be completed by human data entry by the Social Care Navigator. The Eligibility Assessment coding provided will trigger accurate referral information.

If a Member is screened and identified as having an unmet HRSN on any associated individual AHC HRSN Screening Tool question and during the Eligibility Assessment confirms their desire to accept the HRSN referral, a corresponding ICD-10 Z code (social condition) and SNOMED-CT code (detailed findings associated with Enhanced HRSN service) will be used to map each identified need.

NOTE: "SNOMED-CT and ICD-10 Z codes will only be used upon a Member's positive screening result and confirmation of their unmet HRSN during the one-on-one Eligibility Assessment with the Social Care Navigator. The condition status should be confirmed during the Assessment."

Eligibility Assessment ICD-10 Z Codes and SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

For Direct Questioning During Eligibility Assessment (Virtual, or In-Person)

Every data field of the MVD integrated into the Eligibility Assessment must be answered by the Member. The Navigator should conduct a comprehensive Eligibility Assessment informed by the Member's identified needs from the HRSN Screening. The Navigator should answer all relevant questions. If a Member's only positive screening outcome was Interpersonal Safety, the Eligibility Assessment ICD10/SNOMED may be left blank.

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 HRSNs. 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.

Person-Centered Goal Setting SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

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.

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

Navigation to HRSN related services: SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

Referral to Enhanced HRSN Services: Care Management SNOMED-CT Codes: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

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.

Intervention Codes for provision of HRSN services: SNOMED-CT: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

New York State has requested updates to the SNOMED-CT codes for HRSN services. SNOMED-CT and other standards organizations meet every month to review and adopt these proposed changes. Some of the changes requested by OHIP have already been scheduled for discussion and potential adoption, while others are still awaiting scheduling.

Proposed Intervention Codes for HRSN services: SNOMED-CT: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to up-to-date coding tables on NYeC's NYHER 1115 Extranet.

To ensure that programmatic needs for Referral specificity 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).

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. SCN Lead Entities will reimburse HRSN service providers in accordance with OHIP approved HRSN Fee Schedule for Screening, Navigation, and Enhanced HRSN services delivered. In order for claims to process, the appropriate HCPCS code and associated modifier must be entered. Note: Modifiers **must** be entered in the same order as they appear below.

Billing and Payment: HCPCS and Modifiers: Please refer to the 1115 SHIN-NY Interoperability Guidance on the NYeC website 1115 page for access to the live documents on NYeC's NYHER 1115 Extranet.