DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

December 18, 2024

Amir Bassiri
Medicaid Director, Deputy Commissioner
New York Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Director Bassiri:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Health-Related Social Needs (HRSN) services and infrastructure protocol for the Medicaid Redesign Team Section 1115 Demonstration (Project Number: 11-W-00114/2). We have determined the services and infrastructure protocol is consistent with the requirements outlined in the demonstration Special Terms and Conditions (STC) and are therefore approving it. A copy of the approved protocol is enclosed and will be incorporated into the STCs as Attachment K.

We look forward to our continued partnership on the New York Medicaid Redesign Team section 1115(a) demonstration. If you have any questions, please contact your project officer, Jonathan Morancy at Jonathan.Morancy@cms.hhs.gov.

Sincerely,

Angela D. Garner -S
Digitally signed by Angela D. Garner -S
Date: 2024.12.18 18:09:49 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations
State Demonstrations Group

Enclosure

cc: Melvina Harrison, State Monitoring Lead, Medicaid and CHIP Operations Group

New York State Health Related Social Need Services Protocol

In accordance with New York's Section 1115 Demonstration Special Terms and Conditions (STCs), this protocol provides additional detail on the requirements for the delivery of Health-Related Social Need (HRSN) services, as required by STC 6.7. The state may claim FFP for the specified evidence based HRSN services identified in STC 6.2. This protocol outlines the Social Care Networks and infrastructure fund use, covered HRSN services, process for identifying eligible individuals, service delivery, the process for determining the services is medically appropriate, and a description of the process for developing care plans based on an assessment of need. The HRSN services (duration, scope, and definitions) are tied to CMS published guidance on HRSN[1,2] and subject to change with updated published guidance.

Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment K. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in this Attachment K, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
   i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
   ii. The state must provide public notice.
   iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.
b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and/or social risk factors than what are included in this approved Attachment K, the state must follow the process below to update the protocol:
   i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 21.

[1] "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program," CMCS Informational Bulletin, published on November 16, 2023.
[2] "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," published on November 16, 2023.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes.
iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process. This restriction is not applicable to the process and scope of changes outlined in STC 3.6.

A. Social Care Networks (SCNs)

New York State will leverage regional Social Care Networks (SCN), as described in STC 6.1, to coordinate the screening and delivery of the HRSN services outlined in this protocol. SCNs will be regional networks of community-based organizations (CBOs) and other providers that will be responsible for HRSN screening, referral, and coordination and provision of HRSN services for Medicaid members. Each SCN will be managed by a lead entity that will be awarded through a competitive procurement. The SCNs will become Medicaid providers and Medicaid Managed Care Organizations (MCOs) will contract with the SCNs for the services for which the SCNs are responsible. The HRSN services include:

- Level One Services for all Medicaid members (as described in STC 6.6.a):
    - HRSN screening and
    - Level One care management services – navigation to existing local, state, and federal resources.

- Level Two Services (Enhanced HRSN Services) for the eligible populations described in STC 6.6.b (Enhanced Population, see Table 3)
    - Level Two care management services,
    - Housing services,
    - Nutrition services, and
    - HRSN transportation services.

SCN entities will coordinate the delivery of social care services to Medicaid members by community-based organizations (CBOs), with support from shared data and technology. SCNs will have the following goals:

- Build and maintain a network of contracted CBOs with the capacity to screen all Medicaid members for HRSNs, in collaboration with regional ecosystem partners (healthcare providers, health care management providers, MMCOs), and provide authorized social care services to eligible Medicaid members to address their HRSNs;
- Ensure greater coordination of social care services for target populations identified in the 1115 waiver amendment (e.g., pregnant persons, criminal justice-involved populations, foster youth, those living with intellectual or developmental disabilities or substance use disorder, etc.);

- Create an improved and more accessible experience for Medicaid members seeking social care services;
- Establish financially and operationally sustainable, self-innovating ecosystems that will continue to deliver services after the end of the 1115 Waiver demonstration period; and
- Promote more equitable delivery of social care services and address the health, racial, ethnic, socioeconomic, and geographic disparities in existing access and quality.

1. Social Care Network Infrastructure Expenditures

The state will provide infrastructure funding to SCNs for operational setup of the program across the waiver period. SCNs will use infrastructure funding to build necessary functionality across the network, including the initial network infrastructure set-up (e.g., onboarding of CBOs), initial set-up and implementation of data and IT platforms, hiring and recruiting of network staff, CBO capacity building and technical assistance activities, contracting, and community and health system partner engagement. The maximum infrastructure funding available for each SCN lead entity will vary by region and based on the number of Medicaid members in the Enhanced Population in the region. The SCN will submit a budget for its infrastructure funding to the State on an annual basis and will report its expenditures on a semi-annual basis. Funding will be distributed following the schedule in *Table 1* and will be limited to the expenses listed in *Table 2*.

Table 1: SCN Infrastructure Funding and Allowable Costs

HRSN Infrastructure Funding	DY 0/ DY 25 04/01/2023 to 03/31/2024	DY 1/ DY 26 04/01/2024 to 03/31/2025	DY 2/ DY 27 04/01/2025 to 03/31/2026	DY 3/ DY 28 04/01/2026 to 03/31/2027	Total
	$0	$260,000,000	$190,000,000	$50,000,000	$500,000,000

Table 2: SCN Infrastructure Funding Allowable Costs

Function	Type of cost	SCN activities covered by infrastructure funding
Data and IT	• People (salaried or vended) • Vendor • Software/ hardware	• All set-up costs associated with procurement, implementation, and/or build out of data and IT platform
Network and partnerships/ communication	• People (salaried or vended) • Materials	• Initial network set-up • Partner engagement • CBO capacity building and technical assistance

Screening and service delivery coordination	• People (salaried or vended)	• Hiring / recruiting • Salaries + benefits for new positions
Contracting and fiscal management	• People (salaried or vended)	• Administration of contracts (MCO, CBO, and other regional ecosystem partner contracts)
Other administrative expenses	• People (salaried or vended)	• Hiring / recruiting • Salaries + benefits for new positions, training, and education
Physical space	• Office space • Office Utilities	• • Costs of office furnishings, supplies, and equipment that support the delivery of HRSN services (e.g., computers, desks, chairs, etc.) • Office utilities include initial set-up costs and investments necessary to begin utilizing office space such as rewiring and set-up fees.

2. Member Identification

As described above, all Medicaid members will be screened for HRSNs. MCOs will send an Enhanced Population Member Roster to the regional SCN monthly through the Statewide Health Information Network for New York (SHIN-NY). The Roster will include indicators of eligibility by flagging all qualifying eligibility criteria as outlined in *Section B HRSN Services: Table 3*. The SCN will use the Roster in their Social Care IT Platform to flag members eligible for the Enhanced HRSN Services. Outreach to members will occur through a no-wrong-door approach and will utilize hospitals, health service providers, Health Homes, and CBOs. The SCN and its network will be responsible for the screening, assessment, eligibility checks, and referral to services.

3. HRSN Screening, Assessment of Need, and Service Delivery

The SCN will contract with all MCOs and qualifying social service providers covering Medicaid members within their respective regions to assist with the delivery of HRSN services under the 1115 Demonstration. The SCN will establish a network of social care providers and ensure they have sufficient experience, training, and capacity to provide the HRSN services authorized under the Demonstration.

HRSN Screening

Medicaid members will be screened annually for unmet HRSNs (additional screenings may occur as needed following a major life change) using the NYS Health Related Social Needs (HRSN) Screening Tool (an adapted version of the Accountable Health Communities (AHC) Screening Tool). The screening tool will contain questions related to the following HRSN domains: housing and utilities, food security, transportation, employment, education, and interpersonal safety. The screening of Medicaid members

across these domains on a regular cadence will help identify unmet HRSNs, tailor services to address those needs, improve access to social care services, and enable a better understanding of how HRSNs are evolving over time.

To ensure that all members can access screening according to their needs and preferences, HRSN screenings will be conducted in multiple modalities, at accessible times, using culturally and linguistically appropriate methods, in accordance with National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Screening will involve asking the predetermined screening questions coupled with empathetic engagement with the member to understand their life context, specific needs, and preferences related to social care services.

Assessment of Need

Following screening and confirmation of unmet HRSNs, the Medicaid member's eligibility for services will be assessed. Medicaid Fee-for-Service (FFS) members and Medicaid Managed Care Members who are identified as having unmet HRSNs, but do not meet Enhanced Population criteria will be navigated to the existing local, state, and federal resources that most appropriately meet their needs as shown in Figure 1 below.

Medicaid managed care members, who screen positive for an unmet HRSN and are determined to meet the Enhanced Population criteria, will be navigated to the social care services that most appropriately meet their needs. Members who meet the social risk factor and clinical criteria and are part of the Enhanced Population (Table 3) will be eligible for the services in *Section B HRSN Services*, as applicable. The assessment process includes checking the member's Medicaid and Enhanced Population statuses, checking the HRSN unmet need and reviewing those unmet needs with the member, asking additional follow-up questions related to existing services and appropriate referrals, and checking the member's clinical criteria if the member was in the Enhanced Population (Figure 2). Assessment factors will be documented in the Medicaid member's care plan.

Figure 1: Member Journey Map

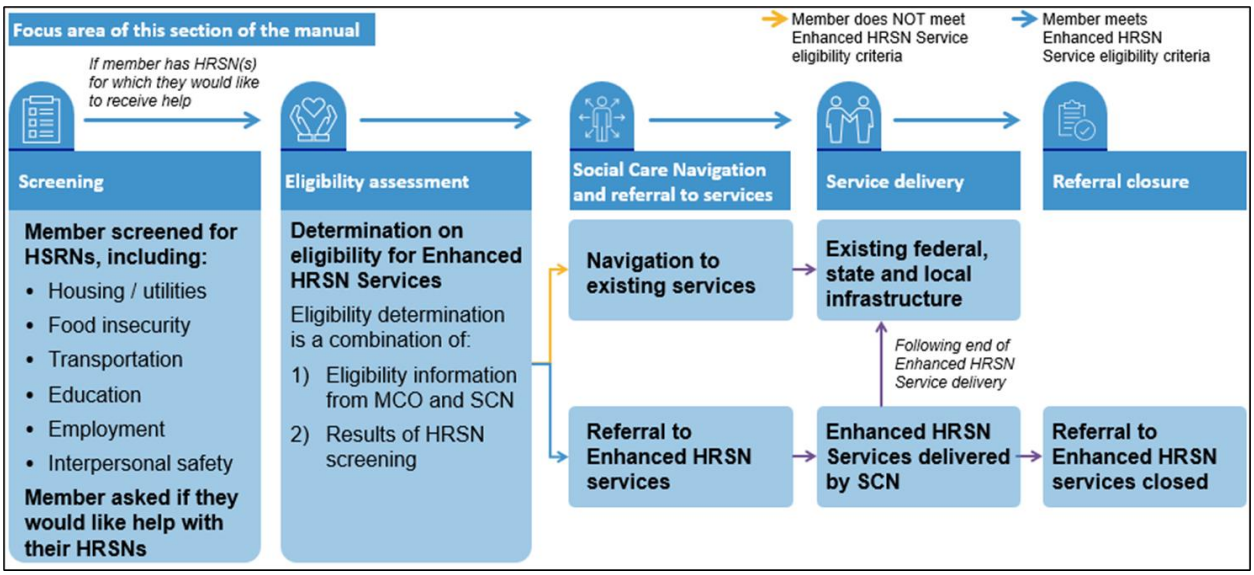

Figure 2: Eligibility Assessment and Coding

Eligibility Assessment
(All Medicaid populations)

Step		Activity*	Details	Data reference	Data output to MDW
	1	**Confirm Member identity and Medicaid enrollment**	Check Member Medicaid enrollment in ePACES	• ePACES	• N/A
	2	**Confirm HRSN**	Check the SCN IT Platform for HRSN screening results and confirm with Member	• AHC HRSN screening results	• ICD 10 Z Codes
	3	**Confirm desire for services**	Inquire if the Member would like to receive services for unmet needs either via existing services or Enhanced HRSN Services	• Member input	• Member responses (Y/N)
	4	**Check Enhanced Population**	Check if Member is part of an Enhanced Population in the Enhanced Services Member File	• Enhanced Services Member File • Member input	• Member responses (Y/N)
	5	**Conduct follow-up questions with Member**	For each unmet HRSN, ask additional follow-up questions, including whether they are receiving existing services	• Questions built into SCN IT platform	• Member responses (Y/N)
If Member is part of an Enhanced Population, complete steps 6-8.	6	**Confirm eligibility for Enhanced HRSN Services**	Check Member eligibility against clinical criteria for particular Enhanced HRSN Services using Enhanced Services Member File	• Enhanced Services Member File • Member input	• Member responses (Y/N)
	7	**Confirm desire for services**	Inquire if Member would like to receive Enhanced HRSN Services for which they are eligible	• Member input	• Member responses (Y/N)
	8	**Create care plan**	Develop care plan for Member on the SCN IT Platform based on unmet HRSNs and eligibility criteria gathered	• Questions built into SCN IT Platform	• SNOMED Goal Codes • Timestamp of care plan creation

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

Service Delivery

Each SCN will work in coordination with CBOs in their network, MCOs, and healthcare and care management providers in their region to deliver services and to ensure there is sufficient capacity to conduct social care service navigation (i.e., screen Medicaid members, validate eligibility, and conduct referral management for eligible Medicaid members). Social care service navigation can be performed by employees of the SCN lead entity; CBOs in the network; or staff of MCOs, healthcare providers, or care management providers, provided these organizations are able to exchange real-time data with these organizations through a shared data and IT platform. SCN lead entities

are responsible for ensuring that all referrals are closed, and services are delivered in a manner that addresses the HRSN of eligible Medicaid members. Referral closure will be validated by SCN lead entities and will be confirmed by the CBO delivering services or by members themselves. All referral data will flow through the SCN's data and IT platform, supported by the SHIN-NY to ensure that the relevant stakeholders can access and track important information about the network's referral closure rate as well as address any unmet Medicaid member needs.

In addition to helping to navigate Medicaid members to the most appropriate social care services, Service Navigators will help ensure social care services are delivered in a manner that sufficiently address the needs of the member. SCN lead entities will be accountable for ensuring that their networks provide Enhanced HRSN Services to address eligible member need in the region.

4. Payment

Payments for Enhanced HRSN Services will flow from the state to the MCOs. The MCOs will make a per-member-per-month (PMPM) payment to the SCNs. The SCN will pay the social care providers for the HRSN screening and services rendered using a fee schedule developed by the SCN and approved by the state. The fee schedules were developed using the methodology listed in the HRSN Fee Schedule submission to CMS. The PMPM will be created by the state and adjusted as needed. New York must follow the established payment methodologies submitted and approved by CMS. The state must submit any changes to the approved payment methodologies to CMS for approval. For screening and navigation services for Medicaid FFS members, the SCNs will submit claims through eMedNY, which is New York's statewide Medicaid Management Information System (MMIS), for approval and will subsequently receive FFS payment to reimburse the rendered services.

5. Enhanced Monitoring and Evaluation Requirements

The state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STC 14.7.b.ii and STC 17.6.a, which require the state to monitor and evaluate how the renewals of recurring nutrition services in STC 6.2.c.v affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 14.6 and STC 17.3, the monitoring protocol and evaluation design are subject to CMS approval.

B. HRSN Services

1. Member Eligibility and Medical Appropriateness

In order to be eligible for the Enhanced HRSN Services and to ensure the services are medically appropriate, the State will require that an individual identified as needing HRSN services meet the following clinical and social risk criteria:

1. Meet the enhanced eligibility criteria for one or more of the covered populations as described below in Table 3;
2. Have a social risk factor, i.e. screen positive for one or more unmet HRSN on the NYS HRSN Screening Tool and is determined to be eligible during a one-on-one assessment with a Social Care Service Navigator (Table 4);
3. Meet specific clinical criteria necessary for specific Enhanced HRSN Services (Table 3); and
4. Meet any additional criteria required under this HRSN Protocol.

2. Covered Populations and Clinical Criteria

Table 3 below describes the covered populations eligible to receive Enhanced HRSN Services, provided they also satisfy the applicable clinical criteria description, social risk, and the HRSN services are determined to be medically appropriate.

Table 3: Enhanced Population Description

Enhanced Population	Clinical Criteria Description
Medicaid High Utilizer (Adults and Children)	• Five or more Emergency Department visits within the last 12 months; or • Four or more Emergency Department visits and one or more Hospital Inpatient stays within the last 12 months; or • Two or more Hospital Inpatient stays within the last 12 months; or • 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
Individuals with Substance Use Disorder (SUD)	An individual diagnosed with a substance use disorder.
Individuals with Serious Mental Illness	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	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 post-partum
Post-Release Criminal Justice-Involved Population with chronic conditions, SUD, or chronic Hepatitis-C	Members who have been released from incarceration within the last 90 days and have a chronic condition*, including substance use disorder and hepatitis C.
Juvenile Justice-Involved Youth, Foster Care Youth, or Those under Kinship Care who are high-risk	Members who: ○ Meet the criteria for juvenile-justice-involved youth or youth involved with child welfare: ○ Juvenile-Justice-Involved Youth: Members 18 years and under released from incarceration within the past 12 months, including those released from state and federal prisons, local correctional facilities, juvenile detention facilities, New York Division of Juvenile Justice and Opportunities for Youth regional facilities, and tribal correctional facilities. Eligibility must be determined within 12 months of discharge ○ Youth Involved with Child Welfare: Members 18 years and under who are currently or have been in the last 12 months: in foster/substitute care; ○ Receiving adoption or guardianship assistance or family preservation services; or

	○ The subject of an open child welfare case in any court; ○ And have at least one of the following: ○ One or more chronic conditions (including mental health diagnosis and SUD) ○ Malnutrition or at risk of developmental or growth delay or impairment as a result of insufficient nutrition as a qualifying condition for nutrition interventions, only, ○ Overweight, obese, or underweight 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 ○ A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect
High-Risk Children	Members 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);a full list of chronic conditions can be found on the New York Health Home program website), • 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; • Mental health condition; or • A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, and neglect.

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

3. Social Risk Factors

In order for individuals in Table 3 to receive the Enhanced HRSN Services (i.e., housing, nutrition, care management, and HRSN service-related transportation) individuals must be screened as having an unmet need in at least one of the domains in Table 4 below

and meet the related risk factor description. The risk factor description will be used to ensure the person is eligible under the Department of Housing and Urban Development (HUD) definition of homeless/at risk of homeless and the USDA definition of low or very low food security.

Table 4: Social Risk Factor

Risk factor	Risk Factor Description
Housing related need for utility assistance and rent/temporary housing	An individual who – Is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5) except for the annual income requirement in 24 CFR 91.5 (1)(i), including those that have: ○ 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.
Housing related need for Home/environmental accessibility modifications	An individual who: Requires a clinically appropriate home modification/remediation service. Has a health condition that is exacerbated by the individual's physical living environment.
Housing related need for community transition services, one time transition and moving costs, Pre-tenancy services, Tenancy sustaining services, Housing transition and navigation services, and medical respite/recuperative care	An individual who is homeless or at risk of becoming homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5 except for the annual income requirement in 24 CFR 91.5 (1)(i).
Nutrition related need for all nutrition interventions	An individual who screens often true or sometimes true to the nutrition questions on the NYS HRSN Screening Tool and meets the USDA definition of low or very low food security.

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.

5. Publicly Maintained Criteria

The State will maintain the clinical and social risk criteria detailed above on a public facing NYS DOH webpage and require that SCNs also maintain these criteria on a public facing webpage. The content will be updated if the criteria is changed. Any changes must be approved by CMS prior to posting.

6. Providing Culturally and Linguistically Appropriate Services

The SCN will provide culturally responsive, trauma-informed services and access to language services. HRSN screenings and services will be conducted and delivered in accordance with National CLAS standards.

7. Non-Duplication of Services

No HRSN service will be covered if it is found to be duplicative of a state or federally funded service or other HRSN service that the member is already receiving. The SCN will work with the MCO and the Medicaid member to ensure that there is no duplication of services.

Medicaid members will be connected to SNAP, WIC and TANF through Level One and Level Two care management.

C. Covered HRSN Services

The State will cover the following HRSN services as defined below:

1. Care Management

Care Management involves 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 Service Navigators will work with members to connect them to the appropriate services to address their HRSNs and align with the members' preferences, limitations, disabilities, etc.

Care Management for either Level One or Level Two will begin immediately by the SCN for any Medicaid member that screens positive for any of the questions on the NYS Health Related Social Needs Screening Tool.

1.1 Level One Care Management (Navigation Services)

Medicaid FFS members who screen positive for an unmet HRSN and Medicaid Managed Care members who screen positive for an unmet HRSN but are ineligible for the Enhanced HRSN Services may be eligible for navigation and referral to existing local, state, and federal benefits and programs. Members that only qualify for Level One services will not receive access to the Enhanced HRSN Services funded under the 1115 demonstration.

Eligibility:
1. Medicaid FFS members who screen positive for unmet HRSN need; or
2. Medicaid Managed Care members who screen positive for unmet HRSN but do not meet the target population criteria (Table 3) for Enhanced HRSN services

Service Limitations and Restrictions:
1. Medicaid members may access navigation, upon receiving one annual screening (or rescreening due to a major life event), for referral assistance to existing local, state, or federal services during the Demonstration period.

Allowable Level One Care Management Providers:

1. Social Care Service Navigators may include employees of the SCN or contracted network CBOs or other social service providers.
2. Providers should have experience connecting vulnerable populations to services.
3. Providers must participate in trainings to ensure that HRSN screenings are conducted in a linguistic and culturally appropriate manner.

1.2 Level Two Care Management (Enhanced Population)

Under Level Two Care Management, the Social Care Service Navigator has the responsibility of providing outreach, assessment, referral management, care coordination, and education – as well as confirming with the member whether the referral was accessed and met their needs. The Social Care Service Navigator will further create a care plan with the member to outline ongoing needs. This includes the plan for Enhanced HRSN Services, as well as referral to, tracking of, and follow-up related to services the member is eligible for and elects to receive.
If applicable, Social Care Service Navigators will coordinate the member's benefit program application assistance, including payment of related fees, and provide connection to clinical care management. All Social Care Service Navigators will be required to follow up with the member at least 60 days prior to the end of the relevant Enhanced HRSN Services and provide referrals to other state, federal, or local services

as needed to ensure continuity of care. If an HRSN service duration is less than 60 days, the SCN will follow up as appropriate.

Service/Care Plan

Each member receiving Level Two care management and/or any Enhanced HRSN Service will have a person-centered care plan that identifies the member's unique needs and individualized strategies and interventions for meeting those needs. Care plans will be developed in consultation with the member and the member's chosen support network, as appropriate, in a culturally and linguistically appropriate way.

The SCN lead entities will be required to create an internal process for the oversight and quality review of care plans. This will ensure all elements of a member's journey within the SCN network are accurately tracked and adequately addressed.

Care plans will include documentation of:

- The date of one-on-one eligibility assessment;
- The Medicaid Managed Care member's eligibility for services;
- Engagement with existing local, state, or federal services or other duplicative services;
- Confirmation that services are available from CBO/social service provider before referring;
- The services the member is being referred to and, if necessary, notes that may allow the SCN to support service coordination between health and social care professionals (e.g., healthcare care managers and providers);
- Follow-up time frames before an Enhanced HRSN Service duration ends; and
- The member's goals related to the Enhanced HRSN Service.

Eligibility:

1. Must be an enrolled Medicaid Managed Care member and
2. Meets at least one of the Enhanced Population criteria for Enhanced HRSN Services in Table 3

Service Limitations and Restrictions:

1. Level Two Care Management may be a standalone service, without a member receiving services in any other Enhanced HRSN Service domains;

2. SCNs will provide care management related to HRSNs only and will not provide any clinical care management.

Allowable Level Two Care Management Providers:

1. Social Care Service Navigators may include employees of the SCN or networked CBOs/social service providers.
2. Providers should have experience connecting vulnerable populations to services.
3. 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 HRSN needs are not directly addressed by the below housing utility services (e.g., fire alarms, lead paint exposure programs, etc.), the Social Care Service Navigator may refer members to existing services under Level Two care management.

2.1 Home Accessibility and Safety Modifications

Home accessibility and safety modification services will consist of limited internal or external physical adaptations made to an 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 and pathways;
- Door and cabinet handles;
- Bathroom facilities;
- Kitchen cabinet or sinks; and
- 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. An assessment of the qualified Medicaid member's primary residence

should be conducted to determine the physical adaptions and modifications necessary to ensure maximum health, welfare, and safety, or to allow the member to function independently in their home. Outcome of dwelling assessment and recommended services must be documented in the Social Care Plan and approved by the Social Care Navigator. The Member's Social Care Plan should include the approved and completed services.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria in Table 3 and social risk factors in Table 4;
2. 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;
3. Has a physical disability that limits independence; and
4. Documentation from Member's provider attesting to medical necessity.

Service Limitations and Restrictions:

1. If applicable, SCNs must document the qualifying clinical criteria for home and safety modifications in the member's 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 the demonstration period.

Allowable Providers:

1. Contracted Home modification service providers that are designated as a non-profit Community Based Organization 501(c)(3).
2. Contracted Home modification services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. Service providers should have knowledge and experience with providing related home accessibility and safety modifications.

2.2 Home Remediation Service

Home remediation services are limited 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.

Home remediation services 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);
- Repairing or improving ventilation systems;
    - Medically necessary repairs or improvement of ventilation systems. May include provisions of devices and appliances that are eligible by clinical criteria:
        - Air conditioners;
        - Humidifiers;
        - Dehumidifiers;
        - Heaters;
        - Air filtration devices.
- Equipment Provision
    - Provision of medically necessary refrigeration units as needed for medical treatment and prevention (e.g., insulin)

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

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors in Table 4;
2. 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 Service Navigator;
3. Medically necessary home remediation services: mold / pest remediation require a health condition or is at risk for a health condition that is exacerbated by the individuals physical living environment.; and documentation from Member's provider attesting to medical necessity.
4. Medically necessary home remediation services: repairing or improving ventilation systems, including air conditioners, heaters, humidifiers, dehumidifiers, and refrigeration, require the following additional clinical criteria to be met.
    a. • 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)

b. • 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.
c. • 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.
d. • Individuals regularly taking medications or have an otherwise stated condition that interferes with daily thermoregulation.

Service Limitations and Restrictions:

1. SCNs must document the qualifying clinical criteria (Table 3) for Home Remediation in the member's 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).
2. Either the SCN or the CBO can contract with the remediation/ventilation company.
3. Contracted Home Remediation services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.

2.3 Asthma Remediation

Remediation services will be available to Enhanced Population members with a diagnosis of asthma and meet the clinical criteria in Table 3. Asthma remediation services will entail the provision of remedial services to remove indoor environmental allergens and the provision of supportive products to eliminate or reduce asthma triggers in the member's home. Remediation services will be tailored to the individual needs of the member and the primary residence (owner-occupied or rental dwelling) of the member. Services may address multiple triggers to improve the home environment

and member's capacity for asthma self-management. Asthma remediation services will include the following components:

a. Asthma Self-Management Education (ASME): health education tailored to the needs of the member and family/caregivers to expand asthma knowledge, such as early warning signs and management of worsening symptoms, asthma control and medication adherence, and identification and reduction of asthma triggers. ASME should be conducted in alignment with national asthma guidelines and support education for a partnership in asthma care. ASME must be provided by a qualified nonphysician health care professional, such as a certified asthma educator (AE-C), respiratory therapist (RT), or specially trained lay health worker (e.g., health educator, community health worker (CHW), etc.), with documented training and demonstrated competency in delivering guidelines-based asthma self-management education and comprehensive home environmental assessments to identify and provide education on reducing asthma triggers. A minimum of two ASME visits (initial and final) must be conducted face-to-face in the primary residence(s) of the recipient 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, virtually face-to-face, or over the phone and must be no earlier than 45 days post completion of all home remediation, to determine changes in asthma control status by administrating and scoring a validated, age-appropriate asthma control screening questionnaire (ACT, C-ACT, TRACK), reinforce education, report member's progress and improvements in the home environment. The SCN should make referrals if necessary for the member or their family if applicable before the Asthma Remediation service duration period ends.

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. Dwelling Assessment & Determination of Scope of Work (SOW): 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. 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 authorized by the SCN prior to being provided. Installation services may address ventilation and air quality, removal of asthma triggers, and Integrated Pest Management (IPM) in alignment with the approved SOW. Total costs of services for Asthma Remediation may not exceed per Member cap listed in the HRSN Fee Schedule for duration of Waiver period.

Remediation services and supportive products include the provision of:

Asthma Trigger Remediation Services	Asthma Supportive Products
Indoor Air Quality	*Asthma Friendly Cleaning Supplies*
Provision of: • Installation of air conditioner • Ventilation system upgrades/installation/repair • Heating unit clean and tune, repairs, or replacement • Forced air-furnace filter replacement and provision of (6) additional filters • Installation/repair of exhaust fan (kitchen and bathroom) • Dryer venting and cleaning • Air duct maintenance • Carpet steam cleaning • Insulation • Air sealing • Replacement of air filters in HVAC system • Humidifier	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 the following only as necessary to support moisture control and water damage: • Plumbing repairs • Repairs to boilers (steam and water) • Repairs to condensate drain • Basement water proofing (coatings, drainage systems) • Sump pump repair/replacement • Carpet removal or removal of moldy wet flooring and installation of Asthma-friendly flooring • Dirt floor vapor barrier basement/crawlspace • • Moisture controlling interventions to repair a source of excess moisture which would otherwise cause a medical condition or harm. • Cleaning/repair/installation of gutter downspout system and gutter screens • *Mold remediation (less than 10 square feet) • *Mold remediation (greater than 10 square feet) *****_Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments._	Provision of: • Vacuum with HEPA filter and filter replacements • Allergen impermeable pillow and mattress encasement
Integrated Pest Management (IPM)	
Provision of: • Sealing or patching cracks or openings in walls, baseboards, and around plumbing • Application of environmentally friendly pesticides, baits, and traps (use away from children and according to manufacturer's instructions)	

• Airtight food storage containers	

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

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors in Table 4;
2. 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;
3. Requires a clinically appropriate home modification/remediation service;
4. Has a health condition that is exacerbated by the individuals physical living environment;
5. Had one or more hospital inpatient stays(s) related to asthma within the last 12 months; or
    a. Two or more ED visits related to asthma within last 12 months; or
    b. Three or more urgent care visits related to asthma within the last 12 months; or
    c. Two or more prescribing events for oral steroid use related to an asthma diagnosis within the last 12 months; or
    d. Three to eleven prescribing events for a rescue inhaler, including albuterol within the last 12 months.

Service Limitations and Restrictions:

1. SCNs must document the qualifying clinical criteria (Table 3) for asthma remediation in the member's care plan.
2. Asthma trigger remediation services and supportive products are limited to those that are of direct medical or remedial benefit to the Medicaid Managed Care member.
3. Asthma remediations must be conducted in accordance with applicable state and local building codes.
4. Services requiring invasive measures will require written approval from property owner (landlord, if the home is rented).
5. Medicaid Managed care member must be a resident of a single-family or multi-unit primary residence owned or rented by a primary caregiver or by oneself.
6. Total costs of services for Asthma Remediation may not exceed per Member cap listed in the HRSN Fee Schedule for duration of demonstration period.

Allowable Providers:

1. Contracted asthma remediation service providers that are designated as a non-profit Community Based Organization 501 (c)(3).
2. Contracted Asthma Remediation service providers may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. 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.
4. Asthma Remediation home improvement contractors must have demonstrated experience providing home installation improvement services for environmental trigger reduction and expanded health and safety measures such as: ventilation, mold remediation, and IPM – as well as experience identifying and remediating asthma-related home environmental triggers. Asthma remediation that is a physical adaptation to a residence must be performed by an individual holding a New York State Contractor's License. IPM should be delivered by professionals licensed by the NYS Department of Environmental Conservation.
5. IPM services including pesticide application must be delivered by professionals licensed by the NYS Department of Environmental Conservation.

2.4 Recuperative Care (Medical Respite)

Recuperative care (Medical Respite) is temporary residential care and supportive services provided to homeless or unstably housed members who do not have an acute need to be hospitalized but require health care services and supports to continue to recover from an illness or prepare for a medical procedure. Services include short-term residential care that allow homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. Recuperative care will be provided in the form of short-term pre and post hospitalization service by NYS DOH certified Medical Respite Programs (MRPs) and in accordance with DOH established Medical Respite regulations (10 NYCRR 1007) and program guidance. Certified MRPs must also offer transitional supports to help members secure stable housing and avoid future hospital readmissions, coordinate with the SCN to offer additional Enhanced HRSN Services to the member when applicable, such as transitional housing navigation services, nutrition supports, transportation, and care management services prior to the member's discharge date from the Medical Respite.

Recuperative care may be used as:

a. Short-term Post Hospitalization Care – provided to eligible members transitioning out of institutions or, acute care hospitals), 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 by the hospital or medical professional.
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.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors in Table 4.

Service Limitations and Restrictions:

1. Individual must be assessed for Medical Respite program eligibility and appropriateness in accordance with state regulations and guidance.
2. Medical Respite's recuperative care may be offered for up to ninety (90) days in duration once every 12 months (assessed on a rolling basis);
3. The combination of pre-procedure and post-hospitalization housing may not exceed 6 months, within each 12-month period.
4. Pre-procedure stays are limited to a clinically appropriate amount of time as authorized by medical professional.
5. Eligible settings for recuperative care, short-term pre-procedure, and post-hospitalization housing will be entities that are certified by the State as Medical Respite programs.

Allowable Providers:

1. State-certified Medical Respite providers who are contracted with the SCN.

2.5 Rent/Temporary Housing

Rent/Temporary Housing includes payment for rent and/or short-term, temporary stays for up to six months for the demonstration period, including rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes, manufactured home lots, motel or hotel when it is serving as the member's primary residence, transitional

and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. Eligible costs include rental payments up to the U.S. Department of Housing and Urban Development (HUD) Fair Market Rate (past-due or forward rent, storage fees, renters insurance, landlord-paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments).

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors in Table 4.

Service Limitations and Restrictions:

1. Rent/temporary housing services are limited to up to six months for the demonstration period. The SCN must ensure that the member is connected to other programming or permanent housing through available local, state, and federal programs by the end of the six-month period.
2. SCNs must document the qualifying clinical criteria (Table 3) for Rent/Temporary Housing in the member's care plan (e.g. transitioning from institution, etc.).
3. Rent/temporary housing services are limited to those eligible members who are willing and capable of living safely within community with appropriate and cost-effective support services. SCNs must document this in the member's care plan.

Allowable Providers:

1. Contracted community-based housing service providers, with experience serving the target population and are registered as a 501(c)(3) non-profit organization.
2. Contracted rent/temporary housing services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. Housing service providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.

2.6 Utility Setup/Assistance

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

and non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills.
This service will cover expenses for the following types of utility payments:

- Garbage
- Water
- Sewage
- Recycling
- Gas
- Electric
- Internet
- Phone (inclusive of landline phone service and cell phone service)
- Utility costs in combined back/prospective payments

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors in Table 4.
2. Must be receiving rent/temporary housing services as described in Section 2.5 on rent/temporary housing.

Service Limitations and Restrictions:

1. Utility Setup/Assistance is limited to up to 6 months in total back/prospective payments and
2. Utility Setup/Assistance is limited to individuals receiving rent/temporary housing services as outlined in Section 2.5.
3. Utility Setup/Assistance is limited to up to 6 months per demonstration.
4. Utility activation fees and/or back payment is limited to a one-time payment assistance, up to a capped amount.
5. 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 the target population that are registered as a 501 (c)(3) non-profit organization.
2. Contracted Utility/Set-up services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
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 and Housing Navigation

Medicaid Managed Care members may qualify for assistance navigating the complexities of the housing search and application process. Under this waiver authority, pre-tenancy and housing transition services will include:

- Assistance with the housing search and application process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance;
- Support during tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews;
- Coordination and navigation assistance with the set-up of the new housing unit, to address needs identified in the person-centered care plan, including clinically appropriate residential modifications to allow the beneficiary to move in and identified needs for assistance with arranging the move and supporting the details of the move, as appropriate;
- Connection to resources aiding with housing costs and other expenses, including linkages to resources for assistance with rental assistance vouchers, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, food and clothing needed at transition, and other related expenses; and
- Review of the living environment to ensure that it meets the clinical needs of the individual and appropriately supports any identified social risk factor. This review should confirm the environment is ready for move-in and include collaborating with the relevant provider staff where the individual is institutionalized (e.g., hospital or facility social worker) to ensure a seamless transition to the community.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors in Table 4 for housing interventions.

Service Limitations and Restrictions:

1. Services are limited to no more than six months, with the exception of housing navigation.

Allowable Providers:

1. Contracted pre-tenancy housing service providers, with experience serving the target population that are registered as a 501(c)(3) non-profit organization.
2. Contracted pre-tenancy housing services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
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 care plan. Assistance with the set-up of the new housing unit and review of the living environment to ensure that it meets the member's clinical, furnishings, adaptive aids, environmental modifications, and food and clothing needs at transition. The following one-time transition and moving costs are included:

- Security deposit, 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.).

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors for housing interventions in Table 4

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 the demonstration period.

Allowable Providers:

1. Contracted community-based housing service providers, with experience providing Community Transitional Support services that are registered as a 501(c)(3) non-profit organization.
2. Contracted community Transitional Support services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 Waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.

2.9 Tenancy Sustaining Services

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

- Assistance in linking to free or affordable legal services for members facing housing-related issues;
- Connection to available resources to assist in establishing a bank account and paying bills;
- Assistance in connecting the member with social services to assist with filling out applications and appropriate documentation to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy;
- Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include direct interventions to address risks and connecting the member to relevant community resources that may offer assistance;
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions; and
- Assistance with housing recertification processes, including lease renewals and housing subsidy renewals.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors for housing in Table 4.

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 the target population that are registered as a 501 (c)(3) non-profit organization.
2. Contracted community-based legal service providers, with experience serving the target population that are registered as a 501(c)(3) non-profit organization.
3. Contracted Tenancy Sustaining housing services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
4. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the 1115 demonstration, 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 will also be connected with SNAP and/or WIC through care management services.

All individuals at the end of the Enhanced HRSN Service duration will also be connected to WIC, SNAP, and/or Older Americans Act Nutrition Services through Care Management services.
Managed Long Term Care Plan and Medicaid Advantage Plan Members are not eligible for 1115 Waiver nutrition services since they are provided as a plan benefit. High-risk pregnant persons and children are eligible for additional nutrition supports where indicated.

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 dietitians/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.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors for nutrition in Table 4.

Service Limitations and Restrictions:

1. Nutritional counseling and education must be approved by Registered Nutritionist/Dietician 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 medically necessary

Allowable Providers:

1. Certified nutritionist or registered nurse dietician.
2. Nutrition services providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.

3.2 Medically Tailored or Clinically Appropriate Home Delivered Meals

a. Home delivered prepared medically tailored or clinically appropriate meals will be available to Medicaid Managed Care members who screen positive for food insecurity and meet specific eligibility requirements. Meal plans will be tailored to the medical needs of the member, approved by a Registered Dietitian Nutritionist (RDN) or Certified Dietitian Nutritionist (CDN), and designed to improve health outcomes, lower cost of care, and increase patient satisfaction. Medically tailored meals benefit is designed for Members with complex or chronic illness and must adhere to standards informed by established nutrition guidelines for specific health conditions and tailored to Member's health condition.
b. 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 populations who are experiencing food insecurity and are at risk for malnutrition and undernutrition.

Eligibility:

1. Meets at least one of the NYHER target population criteria for Enhanced HRSN services in Table 3 and risk factor for nutrition in Table 4.

Service Limitations and Restrictions:

1. This service is limited to three (3) prepared meals a day for up to 6 months at a time.
2. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 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. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.
3. Additional meal support is only permitted when provided to the household of a child or pregnant member meeting the definition in Table 3 Covered Populations.
4. Meals can only be delivered to the enrolled member's home or private residence.
5. Members who receive home delivered medically tailored or clinically appropriate meals cannot also receive Pantry Stocking (Fresh Produce and Non-perishable Groceries) or Medically Tailored/Nutritionally Appropriate Food Prescription.

Allowable Providers:

1. Contracted Home Delivered Meal service providers that are designated as a non-profit Community Based Organization 501 (c)(3).
2. Contracted Home Delivered Meal services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. Providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.

3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions

Medicaid Managed Care members who screen positive for food insecurity and meet eligibility criteria may be eligible for medically tailored or nutritionally appropriate food prescription. Qualified members may elect to receive this service either as a nutrition voucher or food boxes.

Medically tailored or nutritionally appropriate food prescriptions issued in the form of vouchers or coupons may be redeemed at food pharmacies, farmer's markets, mobile markets, and Community Supported Agriculture (CSA) subscriptions. Members who opt for food boxes will receive a weekly delivery of fruits, vegetables, and protein boxes.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN Services in Table 3 and social risk factors for nutrition in Table 4 and

Service Limitations and Restrictions:

1. This service is limited to weekly delivery of fruit and vegetable prescriptions, and protein boxes.
2. This service is limited to three (3) prepared meals a day for up to 6 months at a time.
3. If the member is a pregnant/postpartum person, then the member may receive these services either throughout their pregnancy and up to 2 months postpartum, or for up to 6 months with an option for renewal for up to 6 months if clinical and social needs factors still apply. For the latter option, the timing of eligibility determination during pregnancy or postpartum period does not affect the allowable duration of benefit. The intervention may apply to subsequent pregnancies/postpartum periods during the demonstration period if the member meets the needs-based clinical criteria at the time of the subsequent pregnancies/postpartum periods. If the member is a child/adolescent (0-18 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.
4. Additional meal support is only permitted when provided to the household of a child or pregnant member meeting the definition in Table 3 Covered Populations.
5. Meals can only be delivered to the enrolled member’s home or private residence.
6. Members who receive Medically tailored or nutritionally appropriate food prescription services cannot also receive Pantry Stocking (Fresh Produce and Non-perishable Groceries) or Medically Tailored or Clinically Appropriate Home Delivered Meals (MTM).

Allowable Providers:

1. Contracted Medically tailored or nutritionally appropriate food prescription providers that are designated as a non-profit Community Based Organization 501(c)(3).
2. Contracted Medically tailored or nutritionally appropriate food prescription providers may be offered by for-profits organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. Providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.

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

Medicaid Managed Care members who screen positive for food insecurity, meet specific population eligibility criteria, and are deemed eligible during assessment with SCN may be eligible for pantry stocking of fresh produce and nonperishable groceries. Provision of this service is limited to children under age 18 and pregnant persons, for up to six months. Pregnant individuals, as defined in Table 3 Covered Populations, may receive fresh produce and non-perishable groceries (pantry stocking).

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN services in Table 3 and social risk factor for nutrition in Table 4

Service Limitations and Restrictions:

1. Pantry stocking service is limited to children under age 18 and pregnant individuals who qualify under Table 3 Covered Populations.
2. Pantry stocking services are provided six months at a time. Services may be renewed if a qualified member still meets the clinical and needs-based criteria above, as determined by the SCN.
3. 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. 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 (0-18 years

of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household.
4. Members who receive Fresh Produce or Non-perishable Groceries (Pantry Stocking) cannot also receive Medically Tailored or Nutritionally Appropriate Food Prescription or Medically Tailored or Clinically Appropriate Home Delivered Meals.

Allowable Providers:

1. Contracted Pantry Stocking service providers that are designated as a non-profit Community Based Organization 501(c)(3);
2. Contracted Pantry Stocking services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. Providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the 1115 Waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.

3.5 Cooking Supplies

Medicaid Managed Care members who screen positive for food insecurity may qualify for cooking supplies that are necessary for meal preparation and nutritional welfare when not available through other programs (e.g., pots and pans, utensils, microwave, refrigerator). The refrigerator listed in this section is independent from the medical refrigerator available under Housing Service.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN services in Table 3 and social risk factors for nutrition in Table 4 and

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's discretion in absence of an available 501(c)(3) Community Based Organization.
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 Services

Transportation services may be available to eligible Medicaid Managed care members that screen positive for a health-related social need and meet additional eligibility criteria for Enhanced HRSN Service and/or Level Two care management services under this 1115 Waiver.

Qualified members may receive access to public or private transportation services (e.g., Uber, Taxi, Lyft, bus, or train pass) to utilize 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 care plan.

Examples of HRSN services and Level Two care management activities 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;
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- Transportation to a Pharmacy;
- 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.

Eligibility:

1. Meets at least one of the Enhanced Population and clinical criteria for Enhanced HRSN services in Table 3 and social risk factors in Table 4.

Service Limitations and Restrictions:

1. Transportation services are not the same as Medicaid transportation and are not tied to it in any way.
2. Transportation services may only be used for activities related to accessing Enhanced HRSN Services and/or care management services.

3. Transportation services may be provided to a qualified member's caregiver or guardian for the direct benefit of the member.

Allowable Providers:

1. Contracted Transportation service providers that are designated as a non-profit Community Based Organization 501(c)(3).
2. Contracted Transportation services may be performed by for-profit organizations at the SCN's discretion in absence of an available 501(c)(3) Community Based Organization.
3. All Contracted Transportation service providers must have a valid: New York or other valid state driver license, vehicle registration, vehicle inspection, Certificate of Insurance, and insurance identification cards.