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Social Care Networks (SCNs)

Opportunities for Health Care & Behavioral Health Provider Participation and Impact

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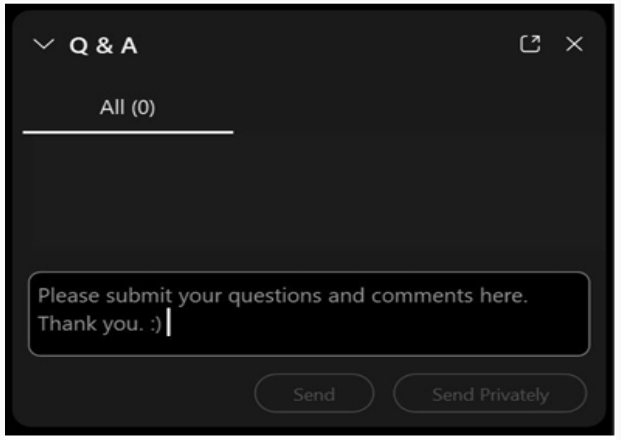
WEBINAR LOGISTICS

- Questions can be submitted using the Q&A function on Webex
- Webinar will be recorded for those unable to join today



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AGENDA

- **Overview of Social Care Networks**
- SCN operational essentials for providers
- Additional resources
- Q&A

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NYHER 1115 WAIVER AMENDMENT OVERVIEW

The NYHER Waiver Amendment is comprised of several initiatives working in concert to ***advance high-quality, equitable care*** for New York individuals and families

Social Care

Social Care Networks (SCNs)

Population Health

Medicaid Hospital Global Budgeting Initiative

Primary Care Delivery System Model

Health Equity Regional Organization (HERO)

Continuous eligibility for children up to age six

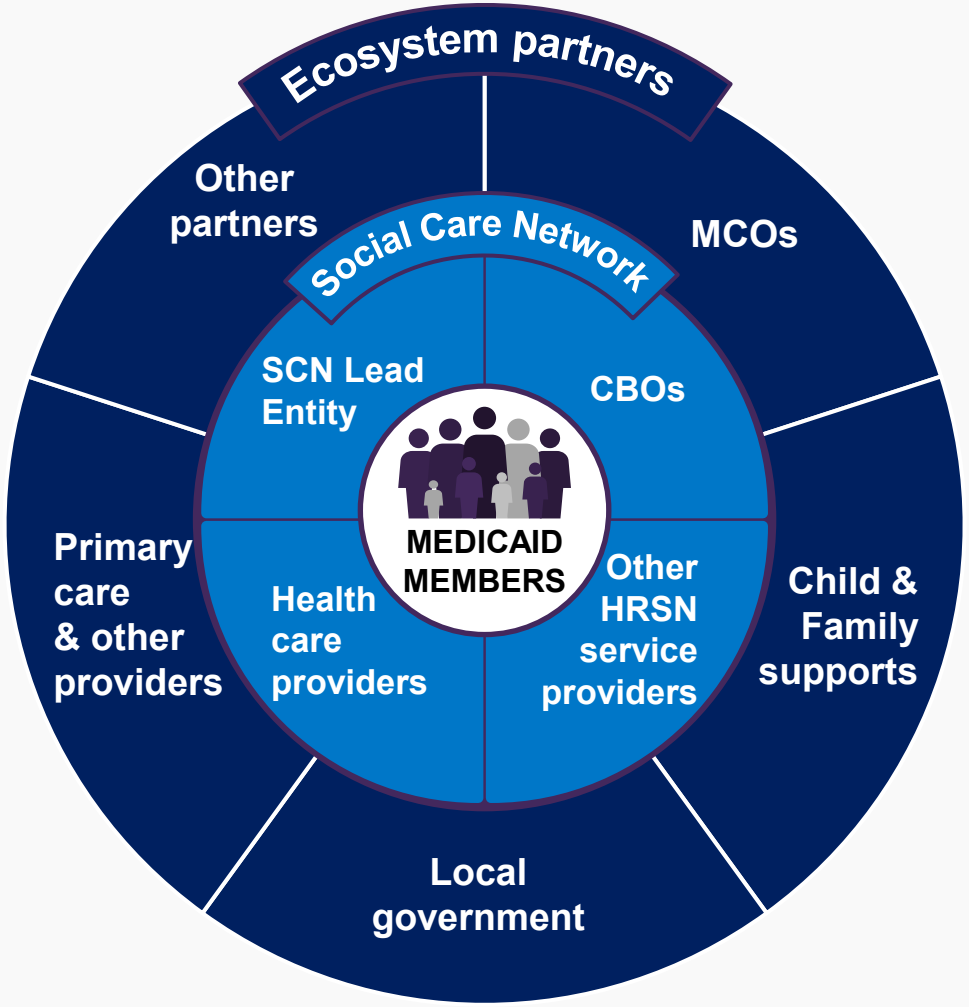
Strengthening the Workforce

Career Pathways Training Program

Student Loan Repayment

SOURCE: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

OVERVIEW OF NEW YORK'S SOCIAL CARE NETWORKS



Social care networks **connect HRSN service providers (including community-based organizations), health care and behavioral health providers,** and **other partners** to:

- ✓ **Increase capacity** for screening and navigation
- ✓ **Reach broader** set of Medicaid populations with enhanced services
- ✓ **Integrate physical, behavioral, and social care** systems through shared data and technology
- ✓ **Facilitate sustainable** Medicaid reimbursement
- ✓ **Improve outcomes and health equity** among New York Medicaid members

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SOURCE: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

OPPORTUNITIES FOR PROVIDERS

The SCN program is **advancing greater integration** of physical health, behavioral health, and social care delivery, supported by new funding, to **meet Medicaid members' whole-person needs**

Health care and behavioral health providers have a critical role in the SCN program and achieving a more integrated delivery system:

Make a difference in Medicaid members' health through screening and connections to housing, nutrition, transportation and other resources

Better coordinate Medicaid member care with community-based organizations and other partners via a shared data / IT platform and continue to track member progress

Receive reimbursement for identifying and addressing unmet health related social needs

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SOURCE: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024; SCN Network Composition reports submitted 2/28/25

HEALTH-RELATED SOCIAL NEEDS SERVICES PROVIDED BY THE SCN

Screening

- Medicaid Members can choose to be screened for HRSNs using the Accountable Health Communities (AHC) HRSN screening tool

Navigation

- Medicaid Managed Care Members are eligible for navigation to existing or enhanced HRSN services
- Medicaid Fee-For-Service (FFS) Members are eligible for navigation to existing local, state, or federal services (e.g., SNAP)

Enhanced HRSN services

Nutrition

- Nutritional counseling and classes
- Medically tailored home-delivered meals
- Food prescriptions
- Pantry stocking
- Cooking supplies (pots, pans, etc.)

Housing

- Medically necessary home modifications and remediation, incl. asthma remediation
- Medical respite
- Rent / temporary housing
- Utility set-up / assistance
- Housing Navigation
- Pre-tenancy services
- Community transitional services
- Tenancy sustaining services

Social care management

- Navigation to social care services (including other enhanced HRSN services and existing services such as education, childcare, interpersonal violence resources, etc.)

Transportation

- Public and private transportation to connect to HRSN services and HRSN care management activities (e.g., get to an appointment with housing navigator)

Duration of each service varies depending on service type and Member need

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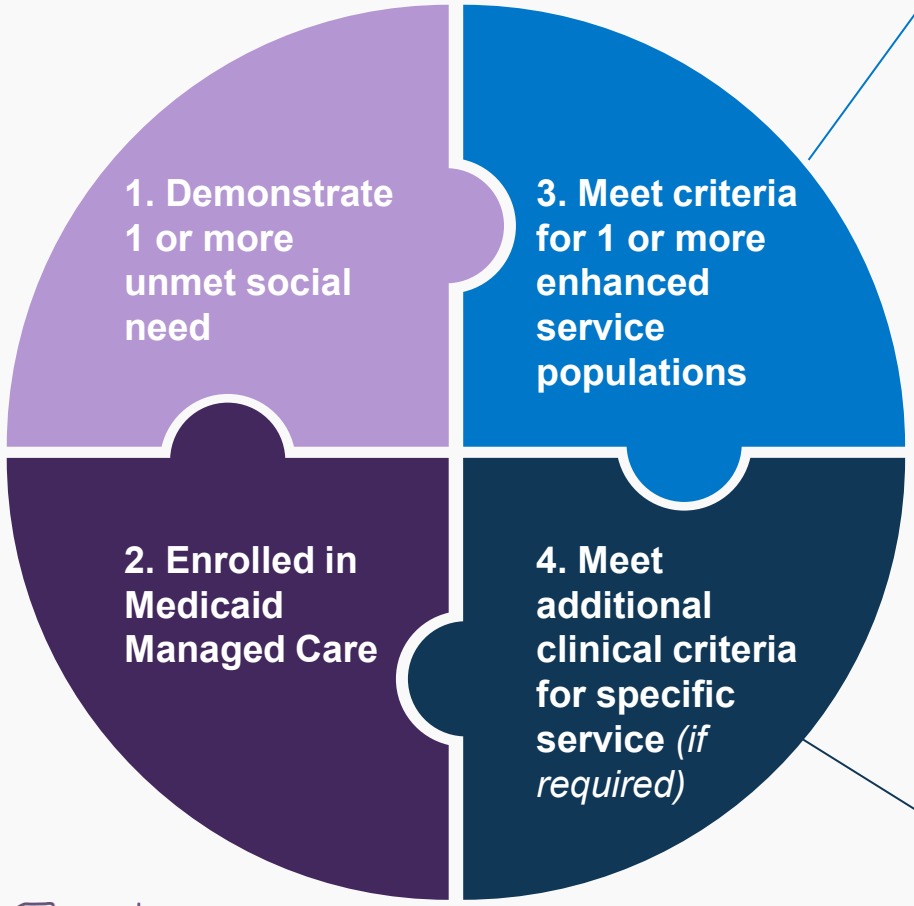
Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

MEMBER ELIGIBILITY FOR SERVICES

Criteria to receive enhanced services



Populations of focus

- Members with substance use disorder and/or serious mental illness
- Members with intellectual and developmental disabilities
- Pregnant or postpartum persons
- Members recently released from incarceration and have chronic health condition(s)
- Children under 18 who are at high risk or have chronic health conditions, including youth in care (e.g., foster care, juvenile justice, kinship care)
- Frequent health care users (e.g., emergency room, hospital stays, transitioning from an institutional setting)
- Members enrolled in a Health Home

Certain enhanced HRSN services will require additional clinical criteria be met (e.g., physical disability)

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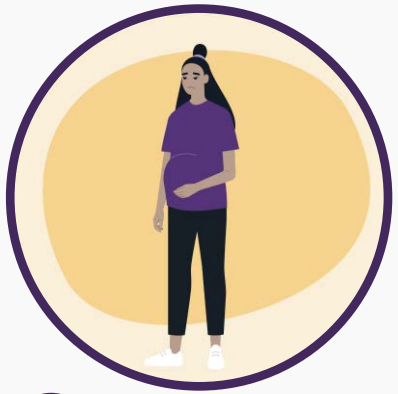
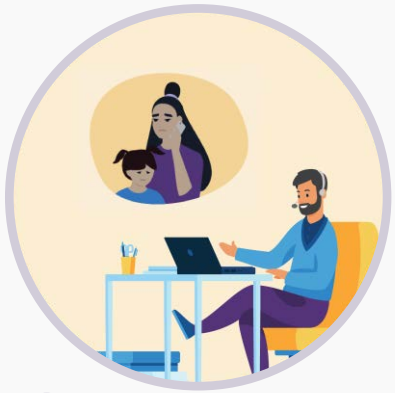
Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

ILLUSTRATIVE EXAMPLE OF MEMBER JOURNEY



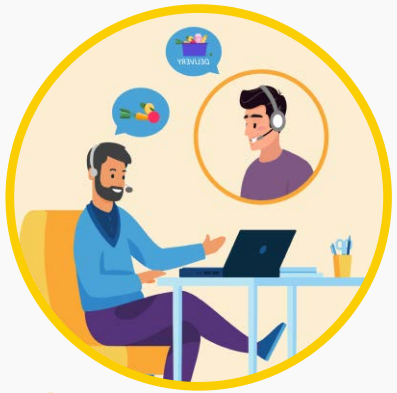
1

Dani is a single mother who is expecting her second child. Dani often runs out of money for groceries by the end of the month



2

Dani's primary care provider screens her, identifying an HRSN for food. The provider refers Dani to the SCN. The SCN Navigator verifies that Dani meets eligibility criteria for food assistance



3

The SCN Navigator creates a referral to a community-based organization that offers food box services

4

The CBO contacts Dani to coordinate food box delivery for her determined service duration

5

Dani receives the food box delivery, helping her to prepare nutritious meals She also gets connected to WIC.

6

Dani's primary care provider sees she has received food assistance via the Statewide Health Information Network for New York (SHIN-NY)[1].

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1 Providers who contract with an SCN will have access to the SCN IT Platform to conduct screenings, navigate members to services, and provide closed-loop referrals, or can use their regional qualified entity to screen.

Source: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

GUIDING PRINCIPLES FOR SCN PROGRAM SUSTAINABILITY

OHIP program design principles to help sustain innovations beyond demonstrations

Invest in evidence-based interventions like medically tailored meals and housing supports that have been shown to improve outcomes and lower cost

Design flexible, scalable models that remove barriers to access through screening and navigation, robust community networks, workforce investments, and integration of existing programs

Balance statewide scale with local and regional needs by harnessing the expertise and experience of community organizations and encouraging cross-sector partnerships

Create accountability through managed care and **incentives** to move **toward value-based payment** for behavioral, physical, and social care

Establish cross-sector data/IT infrastructure with HIE as the backbone, and platforms with common workflows and data standards

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AGENDA

- Overview of Social Care Networks
- **SCN operational essentials for providers**
- Additional resources
- Q&A

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JOINING A SOCIAL CARE NETWORK

Providers who are interested in joining an SCN will engage in several key activities:

1. **Contract with regional SCN(s)**
2. **Onboard and receive training on screening, navigation, and other activities**
3. **Exchange data with the SCN IT platform**
4. **Deliver services and receive reimbursement**

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Source: Social Care Networks program information and Operations Manual

1 CONTRACTING WITH AN SCN

Each SCN Lead Entity is responsible for establishing a network of contracted providers. To contract with an SCN, a provider organization must:

- Be in Medicaid Good Standing – this can include health systems, FQHCs, HealthHomes, CCBHCs, among others
- Do at least one of the following: HRSN screenings, navigation, and/or enhanced service delivery
- Complete the SCN's application, including submitting necessary documentation (e.g., tax identification number, proof of insurance)

Providers who operate in more than one SCN region can contract with multiple SCN Lead Entities.

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Source: Social Care Networks program information and Operations Manual

2 SCN TRAINING FOR PROVIDERS

SCN Lead Entities support participating providers with training and technical assistance, on topics such as:

- **Using the SCN IT Platform to support members and coordinate care**
- **Workflows for key program activities including screening, navigation, and/or providing enhanced services**

Additional trainings vary by SCN and the provider's role, but may include topics like cultural and linguistic responsiveness and trauma-informed approaches

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3 OVERVIEW OF SCN DATA/IT PLATFORMS

Regional SCN IT platform features

- Screening via AHC tool
- Eligibility Assessment
- Navigation and closed loop referrals
- Regional network of social care service providers
- Fiscal management & invoicing
- Training and technical assistance

SCN IT platforms

- Channels360
- Findhelp
- TogetherNow
- Unite Us

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Source: Social Care Networks program information and Operations Manual

3 WAYS TO CONNECT TO SCN DATA/IT SYSTEM

Options		Reimbursement for screening	Reimbursement for navigation
1 SCN IT Platform	1a **SCN IT Platform *without* an EHR connection:** Provider completes activities within the SCN IT Platform portal; data does not flow into provider's EHR	✓	✓
	1b **SCN IT Platform *with* an EHR connection:** Provider completes activities in EHR; data is integrated within the SCN IT Platform	✓	✓
2 EHR connection to SHIN-NY	2a **Connection between EHR and a QE:** Provider completes screenings in their EHR, and data is sent to SCN via the regional qualified entity (QE)	✓	
	2b **FHIR application embedded in EHR:** Provider completes screenings from an 'app' that is bolted onto their EHR, which sends data to SCN via regional QE	✓	
3 SHIN-NY clinical portal	3 **QE clinical portal:** Provider completes screenings in their QE's clinical portal which sends data directly to the SCN	✓	
4 Self-screenings	4 **Self-screenings:** Patient completes self-screenings prior to visit, and provider reviews and submits data through the options above	✓	

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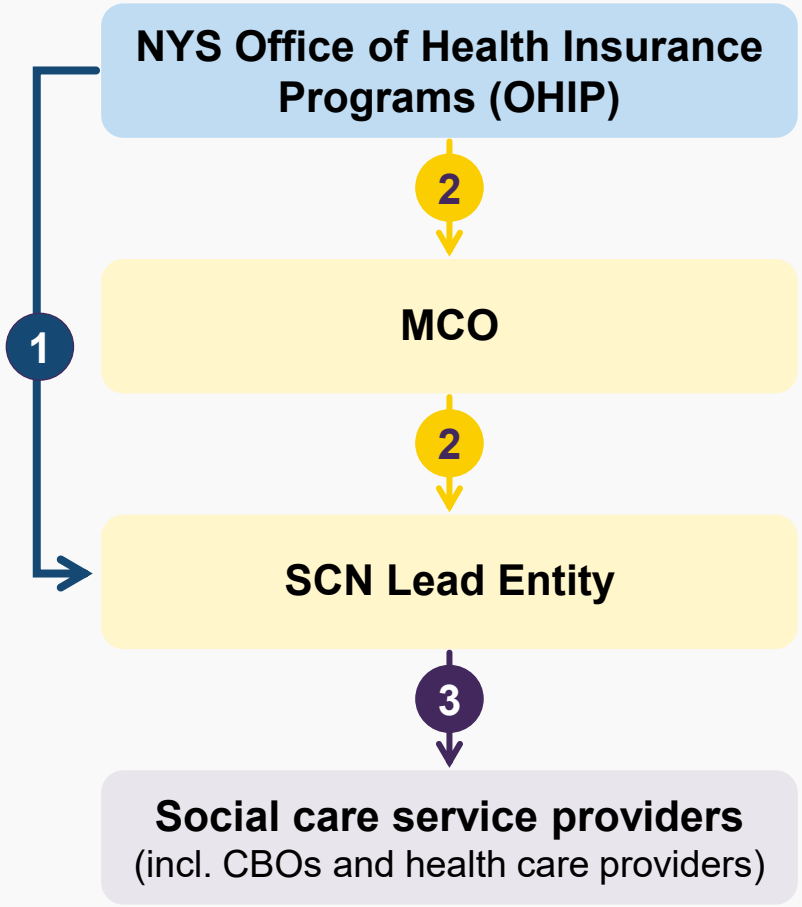
Source: SCN Data and IT Factsheet

4 HOW PAYMENTS ARE MADE TO NETWORK PROVIDERS



1 **Infrastructure grant funding:** Funding to SCN Lead Entities 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 the NYS Office of Health Insurance Programs (OHIP) to the MCOs and from MCOs to SCN Lead Entities

3 **Payments for services delivered:** SCN Lead Entities will pay for screening, navigation, and enhanced HRSN services delivered according to a set fee schedule by region

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Source: Social Care Networks program information and Operations Manual

4 REIMBURSEMENT FOR HRSN SCREENINGS AND NAVIGATION

Screening

$17.50 / 15 minutes (up to $35 / screening)

- Conduct screenings using AHC HRSN Screening tool
- Must be a member's annual screen or re-screen due to a major life event
- Can be conducted within or outside of SCN IT platform

Navigation

$17.50 / 15 minutes (up to $70 per event or $350 per month[1])

- Time spent engaging with member or member representative (e.g., parent, guardian) on eligibility or referrals to services
- Must be conducted using the SCN IT Platform
- Can be provided by non-clinical staff, such as care managers, resource coordinators, or community health workers

Illustrative examples for reimbursement:

Screening: A provider organization that screens around **500 members per month** could receive **between $105,000-$210,000 annually** just for screening.[2]

Navigation: A single full-time navigator employed by a provider organization can generate **$100,000 or more in annual reimbursement** for navigation services.[3]

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1. Navigators can receive up to $70 per event for navigation to existing local, state, or federal services; they can receive up $350 for navigation to enhanced HRSN services
2. Screening is calculated at $17.50 to $35 per member screened, depending on time spent on screening; monthly screening reimbursement is between $8,750 and $17,500.
3. Navigation is calculated at $17.50 per 15 minutes with up to 25 navigation encounters per day in a full-time role.

Source: Social Care Networks program information and Operations Manual

4 REIMBURSEMENT FOR ENHANCED HRSN SERVICES

Social care management

$17.50 / 15 minutes (up to $350 per month)

- Includes referral management, follow-up, and Social Care Plan completion
- Must be conducted using the SCN IT Platform
- Can be provided by non-clinical staff, such as care managers, resource coordinators, or community health workers

Nutrition | Housing | Transportation

Rates for these services are based on regional fee schedules

- Guidelines for service delivery and reimbursement vary by type of enhanced service (e.g., service limits, allowable provider types)
- More details are available via each regional SCN Lead Entity and the OHIP SCN website

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1. Screening is calculating at $17.50 to $35 per member screened, depending on time, monthly screening value is between $8,750 and $17,500.

Source: Social Care Networks program information and Operations Manual

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SCN PROGRAM RESOURCES

Resources for providers:

- New York Social Care Networks Website: Information for Health Care Providers
- Video: Role of Health Care and Behavioral Health Providers in the SCN Program
- Social Care Networks: Introduction for Health Care Providers
- SCN Data and IT Fact Sheet for Providers
- For questions on NYHER Amendment programs, email NYHER@health.ny.gov

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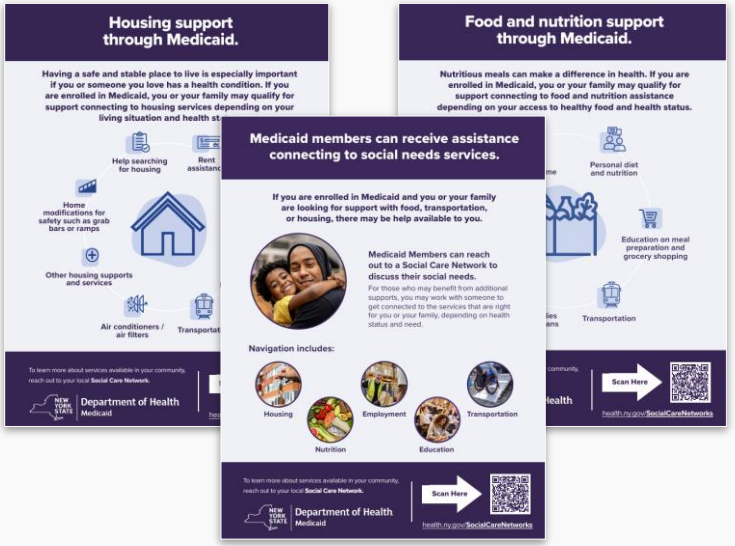
Information for Medicaid members

- **SCN video for members** (in English and Spanish)
- **SCN factsheets** (in English and Spanish)



REGIONAL LEAD ENTITIES AND WEBSITES

Reach out to your regional SCN Lead Entity for information on how to get involved, including how to join one or more Networks

Coverage area	SCN Lead Entity
North Country	Healthy Alliance Foundation Inc.
Central NY	Healthy Alliance Foundation Inc.
Capital Region	Healthy Alliance Foundation Inc
Western NY	Western New York Integrated Care Collaborative Inc.
Finger Lakes	Forward Leading IPA, Inc
Southern Tier	Care Compass Collaborative
Hudson Valley	Hudson Valley Care Coalition, Inc.
New York City[1]	Public Health Solutions
Bronx	Somos Healthcare Providers, Inc.
Staten Island	Staten Island Performing Provider System
Long Island	Health and Welfare Council of Long Island

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1. Includes Brooklyn, Manhattan, and Queens

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- Overview of Social Care Networks
- How the Social Care Network program works
- Additional resources
- **Q&A**

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