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Social Care Networks (SCNs)

An Introduction for Providers

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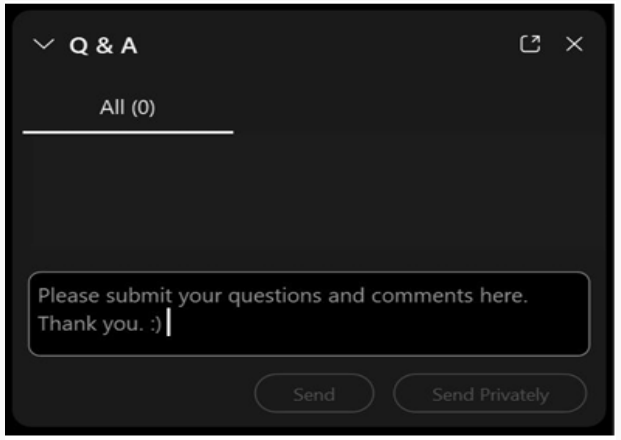
DECEMBER 12, 2024

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

How the Social Care Network program works

Role of providers and how to get involved

Q&A

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VISION FOR AN EQUITABLE AND INTEGRATED DELIVERY SYSTEM

CURRENT CHALLENGES

Fragmented systems that inadequately address social drivers of health

Insufficient care workforce

Increasing health disparities for at risk populations

Lack of regional alignment on objectives and accountability for outcomes

OUR FUTURE

Transform systems to integrate health, behavioral health, and social care

Increase the availability and resiliency of our health care workforce

Reduce long-standing racial, disability-related, and socioeconomic health disparities

Increase health equity through measurable improvement of care quality and outcomes

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

NYHER 1115 WAIVER AMENDMENT INITIATIVES

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

Continuous eligibility for children up to age six

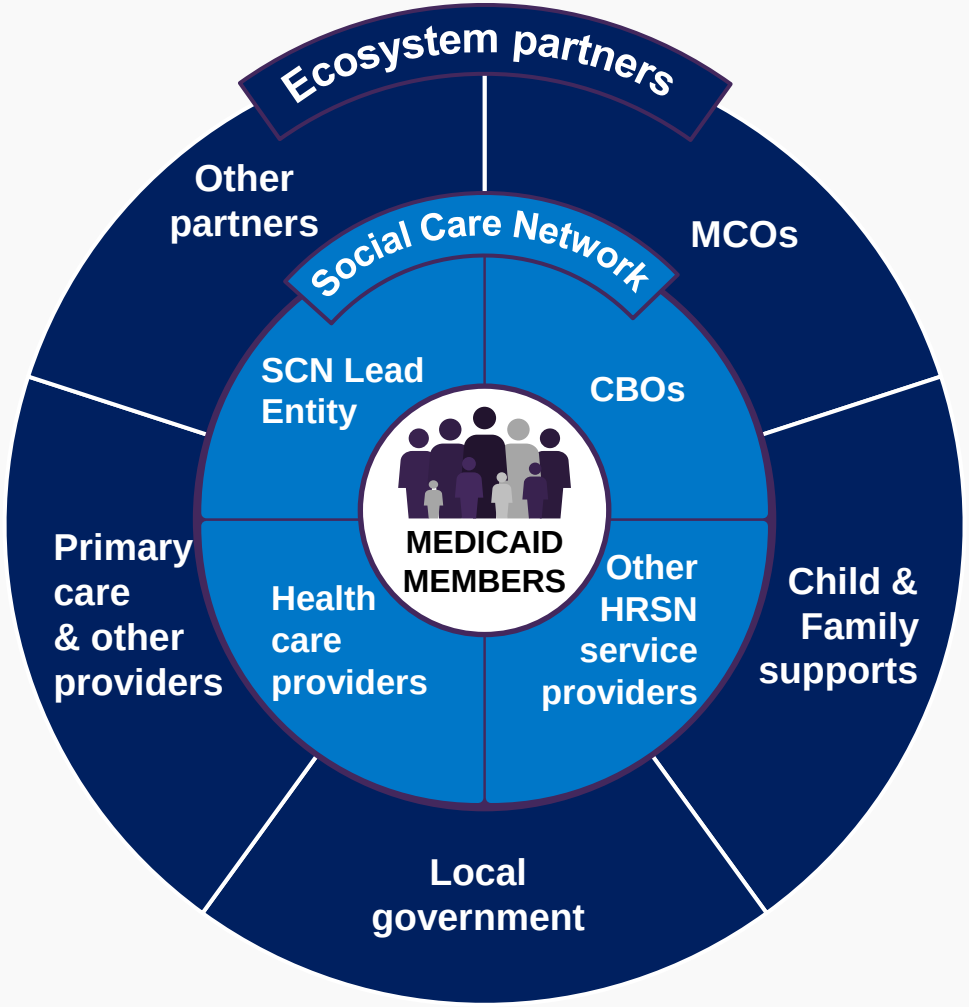
Strengthening the Workforce

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 SOCIAL CARE NETWORKS



Social care networks connect **community-based organizations, providers,** and **other partners** such as insurers and local government to provide **screening, navigation, and delivery of health-related social needs services** to New York Medicaid Members, supported by new **funding, reimbursement, and shared data and technology**

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

OBJECTIVES OF SOCIAL CARE NETWORKS

Increase **capacity to identify unmet social needs** and **navigate Members to services** like food, housing, and transportation

Reach broader set of Medicaid populations with **enhanced services** like medically tailored meals

Integrate **physical, behavioral, and social care systems** through **shared data and technology**

Facilitate sustainable Medicaid **reimbursement** for community-based services that improve health

Improve outcomes and health equity across New York State through improved experience, use of preventive care, and reduced avoidable hospitalizations and institutional care

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

REGIONAL SCN LEAD ENTITIES

	Social Care Network Lead Entity
North Country	
Central NY	Healthy Alliance Foundation Inc.
Capital Region	
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

Source: Governor Hochul Announces $500 Million for New Social Care Networks Program to Deliver Social Services and Improve Health Outcomes for Millions of Low-Income New Yorkers. August 7, 2024. Press Release

AGENDA

- Overview of Social Care Networks
- **How the Social Care Network program works**
- Role of providers and how to get involved
- Q&A

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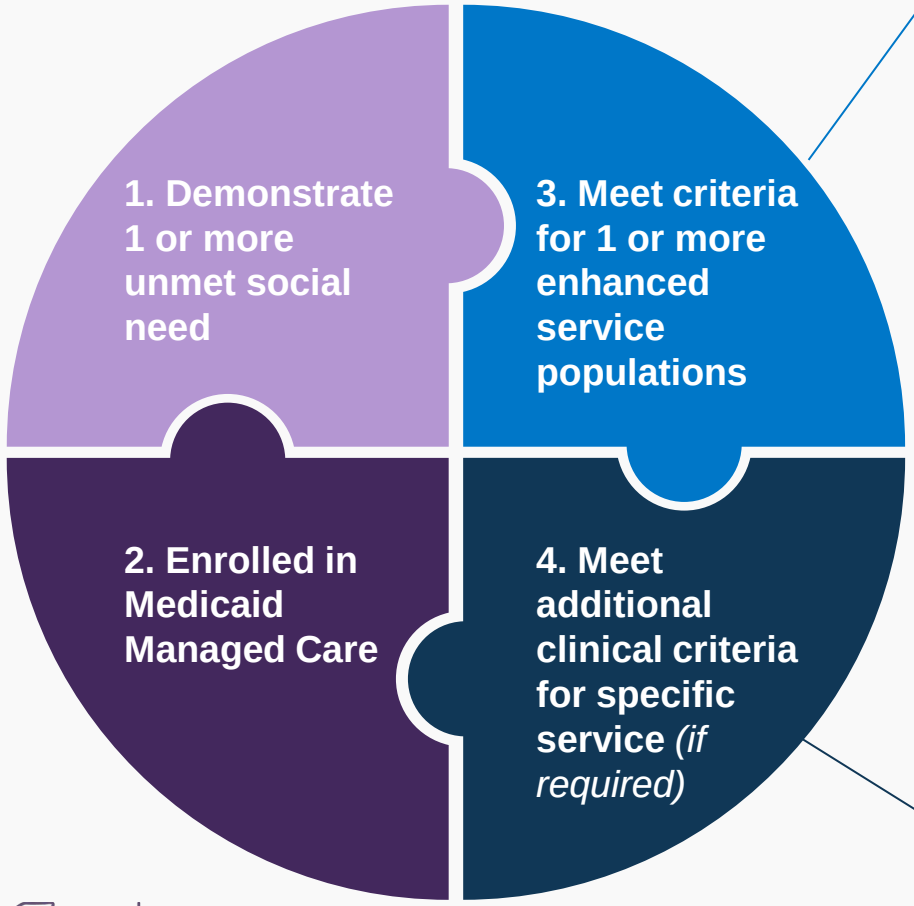
WHO IS ELIGIBLE FOR SERVICES?

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

WHAT HEALTH-RELATED SOCIAL NEEDS SERVICES ARE AVAILABLE?

Screening

- Medicaid Members can choose to be screened for HRSNs using the Accountable Health Communities 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

- Reimbursement for 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

WHAT IS THE MEMBER JOURNEY?

Screening

Screenings will be conducted using the standardized AHC tool

There are a range of individuals and channels that may conduct screening including SCN Navigators, HRSN service providers, Health Homes, FQHCs, providers, behavioral health providers, hospitals, etc.

Members may also self-screen on the SCN website

Social care navigation[1]

Social Care Navigators conduct eligibility assessment, gathering information through the following channels:

1. Member information from MCO (e.g., claims data)
2. Additional information gathered by the Social Care Navigator (e.g., discussion with Member, requesting provider attestation)

Social Care Navigators may be employees of the SCN lead entity or contracted in the SCN

HRSN services

Enhanced HRSN services

Eligible Members are referred to HRSN service providers in the Network for enhanced HRSN services

Existing services

Any Member can receive navigation to existing federal, state, and local services

Enhanced HRSN services to existing services

The Navigator ensures that the Member has their needs met related to the service

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1. Members can be navigated to enhanced services by SCN Social Care Navigators or providers.

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

HOW DO SHARED DATA / IT SUPPORT SERVICE DELIVERY?

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

Examples of SCN IT platforms

- Channels360
- Findhelp
- TogetherNow
- Unite Us

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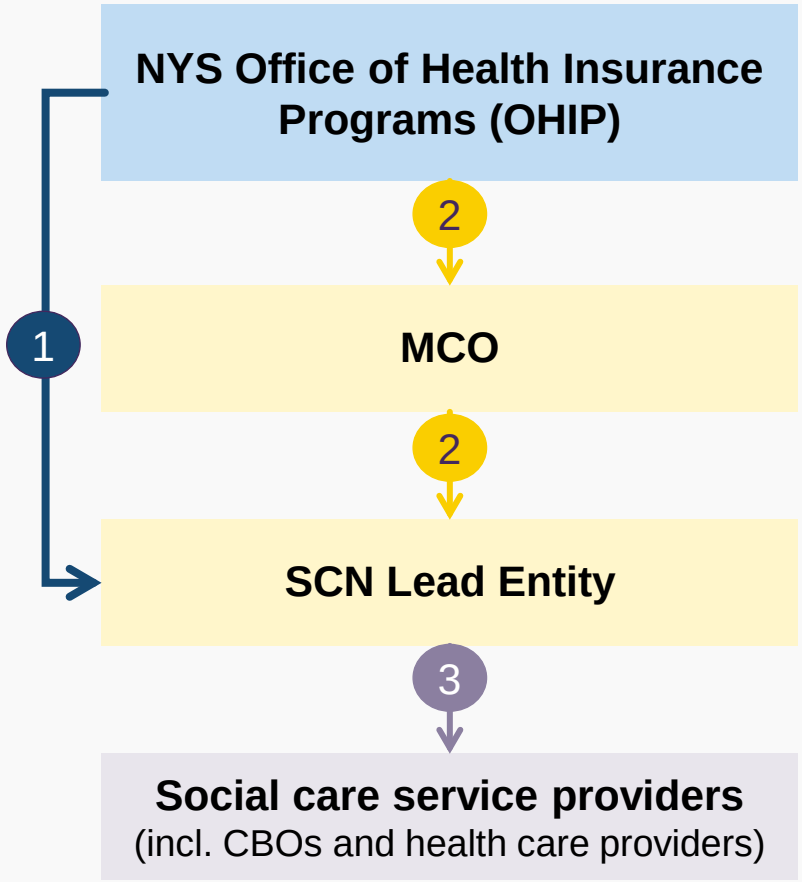
Source: Social Care Networks program information and Operations Manual

HOW ARE PAYMENTS MADE TO SERVICE 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: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

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OPPORTUNITIES FOR PROVIDERS

The SCN program is ***advancing a systematic approach*** to HRSN service delivery and ***greater integration*** of physical health, behavioral health, and social care to enable providers in the ecosystem to collectively

meet Members' whole-person needs.

Providers are a critical partner to this program's success.

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PROVIDERS' ROLES IN SOCIAL CARE NETWORKS

1. Join regional SCN(s)
2. Screen patients for HRSNs
3. Connect patients to regional Social Care Network
4. Support Member eligibility assessments (attestation)
5. Deliver social care services

Providers who contract with one or more SCNs will receive:

- Reimbursement for HRSN screening and service navigation
- Training and technical assistance
- Greater connectivity with other SCN partners via the shared IT platform

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Source: Social Care Networks (SCN): Introduction for Health Care Providers, November 2024

WHAT IS PROVIDER ATTESTATION?

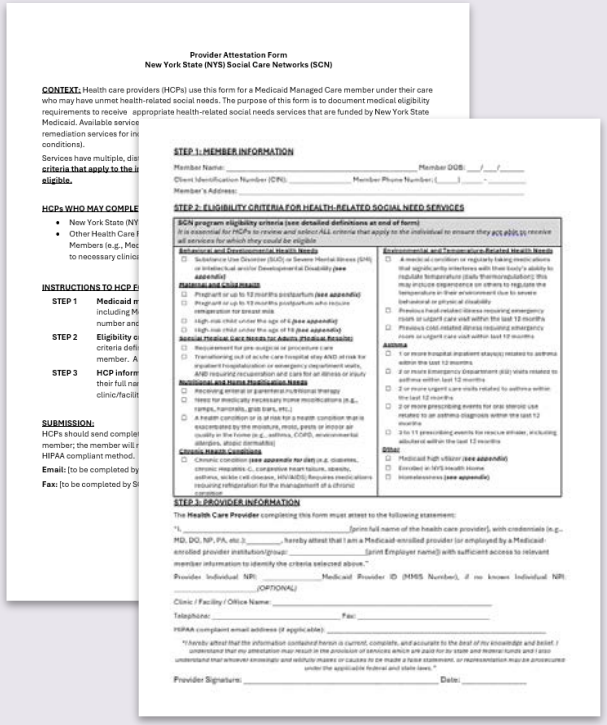
Provider attestation process

- Providers may be asked to attest to Member clinical criteria when **select information is not available** through other means (e.g., health plan data)
- Attestation would involve completing a standardized form brought to a provider by a **Social Care Navigator** or a **Medicaid Member**

Example criteria for provider attestation

- Behavioral and developmental health needs (e.g., SUD, SMI)
- Nutritional needs (e.g., receiving parenteral nutritional therapy)
- Medically necessary home modification needs (e.g., ramps, grab bars)
- Environmental and temperature-related needs (e.g., previous heat-related illness requiring emergency room or urgent care)

Provider attestation form



Provider Attestation Form
New York State (NYS) Social Care Networks (SCN)

CONTEXT: Health care providers (HCPs) use this form for a Medicaid Managed Care member under their care who may have unmet health-related social needs. The purpose of this form is to document medical eligibility requirements to receive appropriate health-related social needs services that are funded by New York State Medicaid. Available service remediation services for in conditions).

Services have multiple, dis criteria that apply to the i eligible.

HCPs WHO MAY COMPLE
- New York State (NY
- Other Health Care F Members (e.g., Mec to necessary clinic

INSTRUCTIONS TO HCP F

STEP 1 Medicaid m including M number and

STEP 2 Eligibility c criteria defi member. A

STEP 3 HCP inform their full na clinic/facili

SUBMISSION:
HCPs should send comple member; the member will HIPAA compliant method.

Email: [to be completed by

Fax: [to be completed by S

STEP 1: MEMBER INFORMATION

Member Name: _____ Member DOB: ___/___/____

Client Identification Number (CIN): _____ Member Phone Number: (___) ___-____

Member's Address: _____

STEP 2: ELIGIBILITY CRITERIA FOR HEALTH-RELATED SOCIAL NEED SERVICES

SCN program eligibility criteria (see detailed definitions at end of form)

It is essential for HCPs to review and select ALL criteria that apply to the individual to ensure they are eligible to receive all services for which they could be eligible.

Behavioral and Developmental Health Needs

- ☐ Substance Use Disorder (SUD) or Severe Mental Illness (SMI) or Intellectual and/or Developmental Disability (see appendix)

Maternal and Child Health

- ☐ Pregnant or up to 12 months postpartum (see appendix)
- ☐ Pregnant or up to 12 months postpartum who require temperature for breast milk
- ☐ High-risk child under the age of 6 (see appendix)
- ☐ High-risk child under the age of 18 (see appendix)

Social Medical Care Needs for Adults (Medical Respite)

- ☐ Requirement for pre-surgical or procedure care
- ☐ Transitioning out of acute care hospital stay AND at risk for inpatient hospitalization or emergency department visits, AND requiring recuperation and care for an illness or injury

Nutritional and Home Modification Needs

- ☐ Receiving enteral or parenteral nutritional therapy
- ☐ Needs for medically necessary home modifications (e.g., ramps, handrails, grab bars, etc.)
- ☐ A health condition or is at risk for a health condition that is exacerbated by the moisture, mold, pests or poor air quality in the home (e.g., asthma, COPD, environmental allergies, atopic dermatitis)

Chronic Health Conditions

- ☐ Chronic condition (see appendix for list) (e.g. diabetes, chronic hepatitis C, congestive heart failure, obesity, asthma, sickle cell disease, HIV/AIDS) Requires medications requiring refrigeration for the management of a chronic condition

Environmental and Temperature-Related Health Needs

- ☐ A medical condition or regularly taking medications that significantly interferes with their body's ability to regulate temperature (calls thermoregulation); this may include experience or others to regulate the temperature in their environment due to severe behavioral or physical disability
- ☐ Previous heat-related illness requiring emergency room or urgent care visit within the last 12 months
- ☐ Previous cold-related illness requiring emergency room or urgent care visit within last 12 months

Asthma

- ☐ 1 or more hospital inpatient stay(s) related to asthma within the last 12 months
- ☐ 2 or more Emergency Department (ED) visits related to asthma within last 12 months
- ☐ 2 or more urgent care visits related to asthma within the last 12 months
- ☐ 2 or more prescribing events for oral steroid use related to an asthma diagnosis within the last 12 months
- ☐ 3 to 11 prescribing events for rescue inhaler, including albuterol within the last 12 months

Other

- ☐ Medicaid high utilizer (see appendix)
- ☐ Enrolled in NYS Health Home
- ☐ Homelessness (see appendix)

STEP 3: PROVIDER INFORMATION

The Health Care Provider completing this form must attest to the following statement:

"I, _____ [print full name of the health care provider], with credentials (e.g., MD, DO, NP, PA, etc.): _____, hereby attest that I am a Medicaid-enrolled provider (or employed by a Medicaid-enrolled provider institution/group: _____ [print Employer name]) with sufficient access to relevant member information to identify the criteria selected above."

Provider Individual NPI: _____ Medicaid Provider ID (MMIS Number), if not known Individual NPI: _____ (OPTIONAL)

Clinic / Facility / Office Name: _____

Telephone: _____ Fax: _____

HIPAA compliant email address (if applicable): _____

"I hereby attest that the information contained herein is current, complete, and accurate to the best of my knowledge and belief. I understand that my attestation may result in the provision of services which are paid for by state and federal funds and I also understand that whoever knowingly and willfully makes or causes to be made a false statement, or representation may be prosecuted under the applicable federal and state laws."

Provider Signature: _____ Date: _____

When attestation is requested, provider will be sent standardized form by Navigator or in some cases, by a Member

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Source: Social Care Networks (SCN): Introduction for Health Care Providers, November 2024

HOW CAN PROVIDERS CONNECT TO SCN IT?

IT platform options

Providers can conduct HRSN screening and navigation using:

1. **SCN IT platform***
2. **Unique IT platform that can feed to SCN IT platform*** (e.g., electronic health record [EHR] or other home-grown system)
3. Unique IT platform that *cannot* feed data to SCN IT platform

**Only screenings and navigation conducted using these options are reimbursable*

How to prepare

To prepare to send screening and navigation data to the SCN:

- Confirm which platform option your organization will implement
- Verify options for integrating AHC screening tool if using EHR
- Determine training needs for selected option to spread key info within your organization

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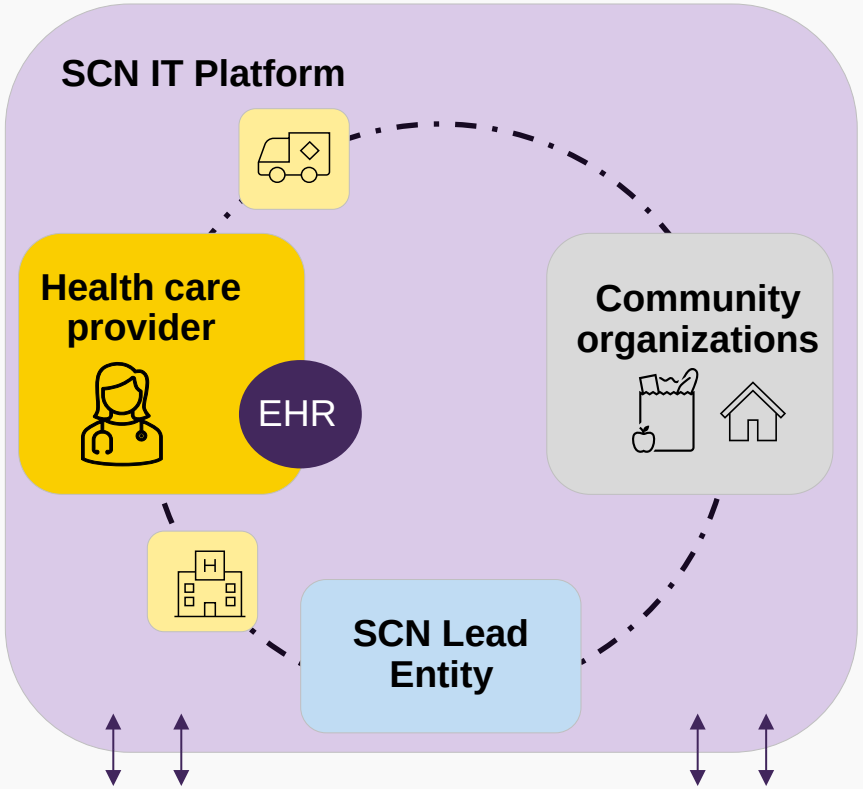
Note: Providers who contract with an SCN to deliver HRSN services beyond screening and navigation will need to onboard to the SCN IT Platform to receive reimbursement

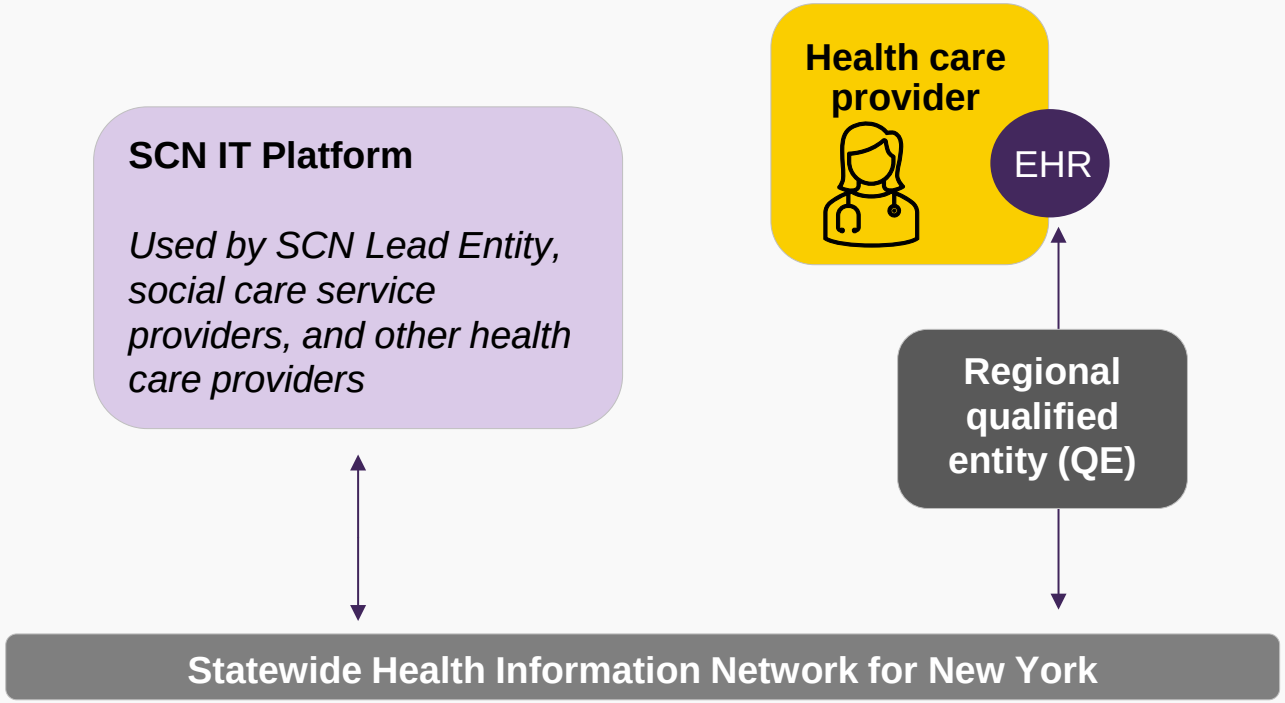
Source: Social Care Networks (SCN): Introduction for Health Care Providers, November 2024

ILLUSTRATIVE DATA FLOWS

Scenario 1: Provider in social care network uses SCN IT platform for screening, navigation, and payments



Scenario 2: Provider uses different platform for screening (e.g., EHR) that connects to qualified entity to enable SCN access to provider screening data



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Sources: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024; Social Care Networks (SCN): Introduction for Health Care Providers, November 2024

NEXT STEPS AND RESOURCES FOR PROVIDERS

- **Reach out to your regional SCN Lead Entity** for information on how to join – there is no deadline to join a social care network
- **Determine which services your organization will provide** (e.g., screening, navigation, HRSN service delivery)
- **Determine which IT platform** your organization will use and go through necessary training
- **Talk to your Medicaid patients about social care networks** and **direct them to the regional SCN beginning in 2025**

New York Social Care Networks Website

Social Care Networks: Introduction for Health Care Providers

Subscribe to MRT Listserv

New York 1115 Waiver Website

For questions on NYHER Amendment programs, email NYHER@health.ny.gov

SCN Lead Entities will provide additional resources to partners in their region, including trainings and Member-facing marketing materials

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REMINDER OF REGIONAL LEAD ENTITIES AND WEBSITES

Reach out to your regional SCN Lead Entity for information on how to participate, 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
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Bronx	Somos Healthcare Providers, Inc.
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