



**Department
of Health**

Social Care Networks (SCNs)

An Introduction for Health-Related Social Need (HRSN) Service Providers

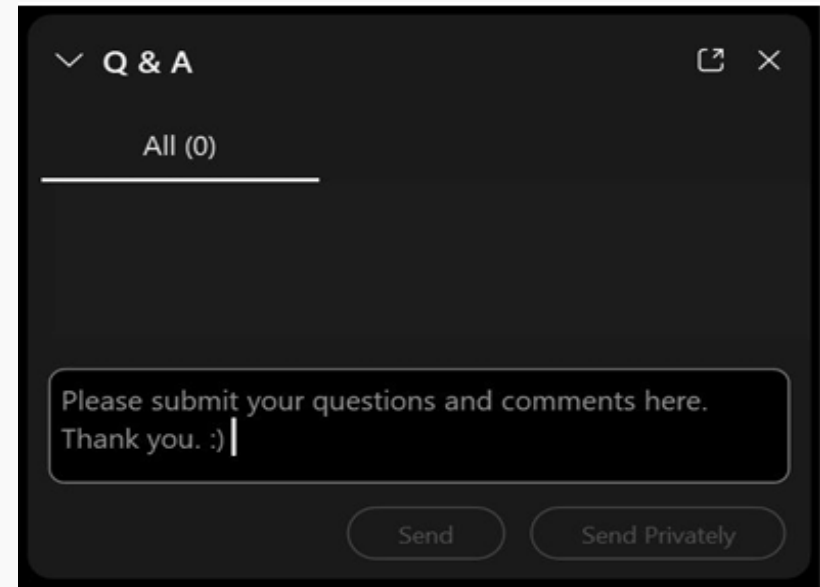
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DECEMBER 19, 2024

WEBINAR LOGISTICS

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



AGENDA

Overview of Social Care Networks



How the Social Care Network program works



Role of HRSN service providers and how to get involved



Q&A



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 care workforce

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

Increase health equity through measurable improvement of care quality and outcomes

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

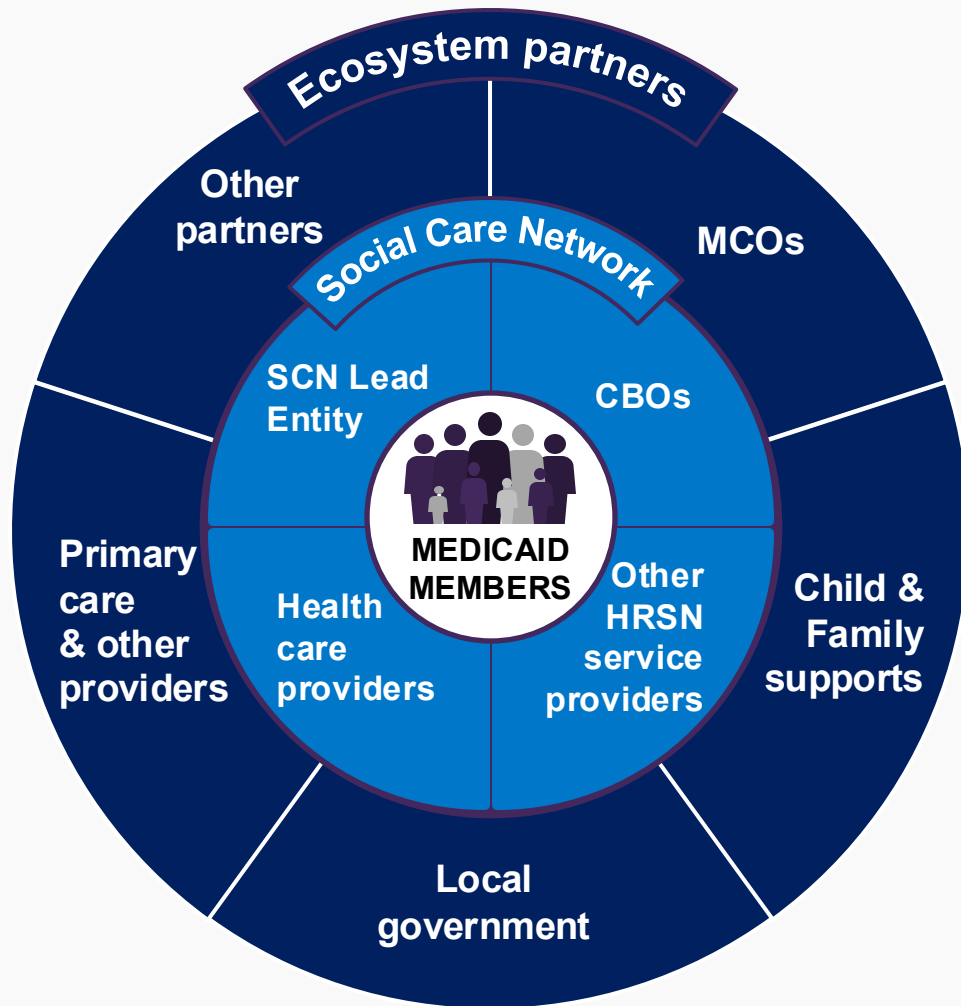


Strengthening the Workforce

Career Pathways Training Program

Student Loan Repayment

OVERVIEW OF NEW YORK'S SOCIAL CARE NETWORKS



Social care networks **connect HRSN service providers (including 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**

OBJECTIVES OF SOCIAL CARE NETWORKS



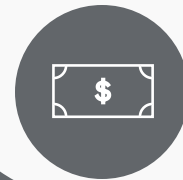
Increase **capacity to identify unmet social needs** and **navigate Members to services** like food, housing, and transportation



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

REGIONAL SCN LEAD ENTITIES

Social Care Network Lead Entity

North Country

Central NY

Capital Region

Western NY

Finger Lakes

Southern Tier

Hudson Valley

New York City¹

Bronx

Staten Island

Long Island

Healthy Alliance Foundation Inc.

Western New York Integrated Care Collaborative Inc.

Forward Leading IPA, Inc

Care Compass Collaborative

Hudson Valley Care Coalition, Inc.

Public Health Solutions

Somos Healthcare Providers, Inc.

Staten Island Performing Provider System

Health Equity Alliance of Long Island



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

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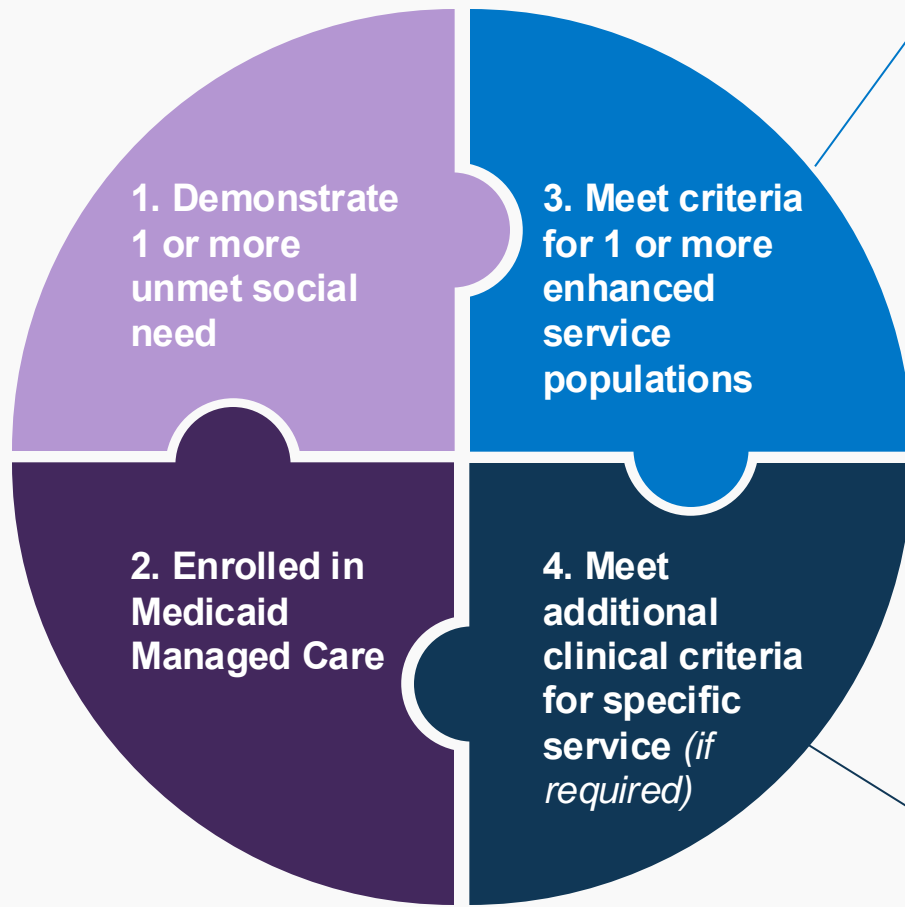


Q&A



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 – including youth involved in foster care, juvenile justice, or kinship care – with select chronic health conditions
- Frequent health care users (e.g., emergency room and hospital stays)
- Members enrolled in a Health Home



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

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)



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

Enhanced HRSN 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)

*Services will be reimbursed based on a regionally-based fee schedule
Duration of each service varies depending on service type and Member need*

EXAMPLES OF ENHANCED FOOD AND NUTRITION SERVICES



Nutrition counseling & education



Meal prep education

Food/diet related planning related to conditions such as diabetes, obesity, etc.

Medically tailored meals



Home delivered, medically tailored or clinically appropriate meals

Food prescriptions



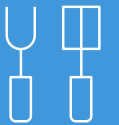
Medically tailored or clinically appropriate food boxes or nutrition vouchers

Pantry stocking



Fresh produce and non-perishable groceries (may include delivery)

Cooking supplies



Provision of materials necessary for meal preparation (e.g., pots, pans, plates, bowls, cups, silverware)

EXAMPLES OF ENHANCED HOUSING SERVICES



Medically necessary home accessibility / safety modifications



- Ramps
- Handrails
- Electric door openers
- Widening of doorways
- Non-skid surfaces

Medically necessary home remediation



- Mold / pest
- Ventilation, AC, heater, etc. repair
- Refrigeration for medical treatment
- Home environment assessment

Asthma remediation



- Home remediation / equipment provisioning tailored to individuals with asthma
- Home environment assessment

Medical respite



- Recuperative care: pre-procedure and post-hospitalization
- Care coordination and connection to supportive housing

Rent / temporary housing



- Rent / temporary housing support (up to six months)
- Utility assistance

Utility set-up / assistance



- Activation expenses and back payments to secure / keep utilities (e.g., electric)

Pre-tenancy services



- Tenant rights education
- Housing interviews
- Application assistance

Community transitional services



- Security deposits
- First month's rent
- Utility activation fees

Tenancy sustaining services



- Eviction prevention
- Fiscal planning
- Emergency planning
- Independent community living skills

Housing transition and navigation



- Assistance with housing search

EXAMPLES OF ENHANCED TRANSPORTATION SERVICES



Transportation services

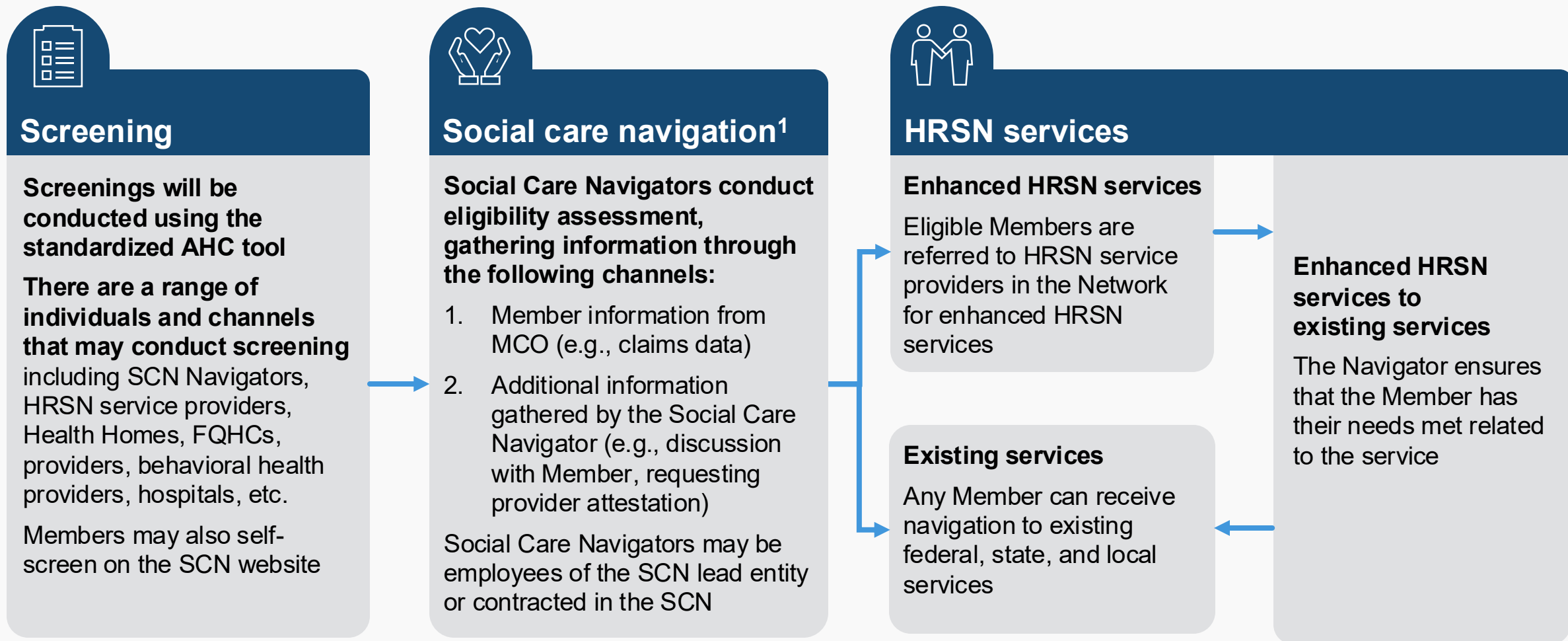


Public or private transportation (e.g., taxi/livery, rideshare/transportation network company (TNC), public transportation) to **utilize enhanced HRSN services and/or social care management activities** for which a Member has been referred including:

- Housing appointments
- Nutrition class
- Pick up of food prescription box

These enhanced transportation services are a separate but complementary benefit to NEMT and meant to be used to access enhanced social care services (not clinical care)

WHAT IS THE MEMBER JOURNEY?



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

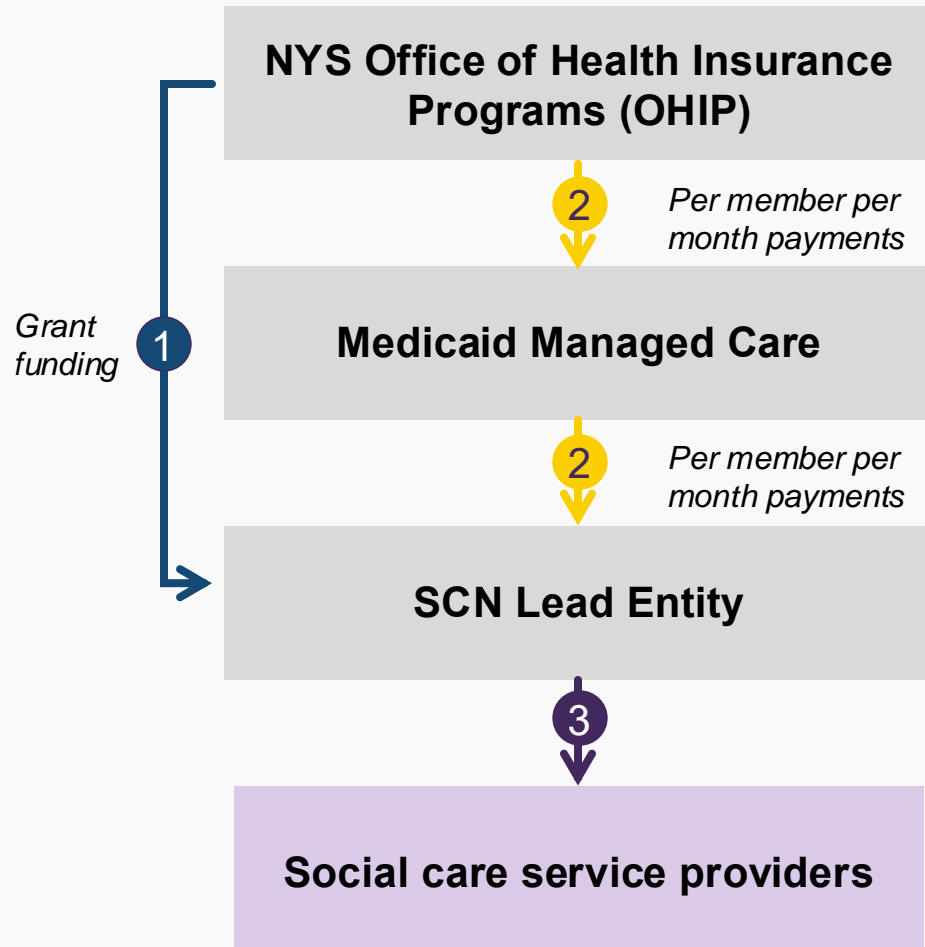
Channels360

Findhelp

TogetherNow

Unite Us

HOW ARE PAYMENTS MADE TO SERVICE PROVIDERS?



Funding through Social Care Networks for HRSN service providers

- A. Reimbursement for social care services delivered:** SCN Lead Entities may pay organizations in the network for screening, navigation, and delivery of enhanced social care services according to a set, regionally-based fee schedule
- B. Capacity-building funding:** Select organizations may qualify for additional funding from the SCN Lead Entity that can be allocated to hire staff members, provide training for staff, purchase equipment, or conduct other activities to build capabilities

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ROLE OF HRSN SERVICE PROVIDERS

In partnership with SCN Lead Entities and other partners, networks of **HRSN service providers will support access to HRSN services that meet individuals where they are and advance collective health equity goals**

Roles of HRSN service providers span the Member journey:



**Screening
Members for
unmet HRSNs**



**Navigating
Members to
services**



**Delivering HRSN
services (e.g., food,
housing,
transportation)**

APPROACH TO HRSN SCREENING



Members will be screened using twelve questions from the **Accountable Health Communities (AHC) HRSN Screening tool¹**



State's goal is for Medicaid Members to receive a screening **annually or after a major life event** (e.g., change to family, hospitalization, new diagnosis, etc.)



Reimbursement for screening requires **contracting with SCN** and **sharing screening data with the SCN IT Platform**



APPROACH TO NAVIGATION

Role of the Social Care Navigator

Social Care Navigators connect Members with HRSNs to services fit to address those needs

Key activities:

- Assess Member eligibility for enhanced HRSN services
- Connect Members to existing federal, state, or local resources, and refer eligible Members to enhanced HRSN services through the SCN
- Follow-up on referrals to ensure the delivery of services

Who can serve as a Social Care Navigator

Social Care Navigators may be employed by the SCN Lead Entity, HRSN service provider, or another entity contracted with the SCN

Examples:

- Community health workers
- Care managers
- Resource coordinators
- Social workers

Funding for navigation

Social Care Navigation may be reimbursed by the SCN Lead Entity based on a set fee schedule, included in contract with the SCN

There may also be funding available from an SCN Lead Entity to support hiring / training of Social Care Navigators (as part of capacity-building funding)

REIMBURSEMENT AND FUNDING

To receive reimbursement, HRSN service providers must:



Do **at least one** of the following:

- Screen Members using the AHC HRSN Screening tool¹
- Navigate Members to services
- Provide enhanced HRSN service(s)



Follow agreed upon **terms as outlined in contract** with SCN Lead Entity



Complete **training and onboarding** to the SCN IT platform, including meet data and reporting requirements

Opportunities of joining an SCN

While providers **cannot receive duplicative payment** for the same service (i.e., if the service is already covered by local, state, or federal funding), they **may braid funding for greater community impact**

SCN funding may be used to:

- Staff a navigator or care manager
- Expand the reach of services your organization currently offers
- Pilot the delivery of new services

ILLUSTRATIVE EXAMPLE OF BRAIDED FUNDING

Community-based housing provider has pre-existing grant from the state...

Funding stream Funding uses – illustrative and not exhaustive

**State grant
for
supportive
housing**

- Provider currently reimbursed for:
- Rental subsidies to eligible populations as part of state grant
 - Housing case management
 - Outreach to identify individuals in need of services
 - Tenancy supports

**SCN
program
payments**

- Provider could be newly reimbursed for:
- HRSN screening via AHC tool
 - Eligibility assessments and navigation to other HRSN services
 - Housing navigation
 - Community Transitional Supports

Example considerations for braided funding:

- What services and populations are eligible through each funding source?
- How will your organization track how funding sources are being used?
- What are the reporting requirements for each funding source?

TRAINING AND TECHNICAL ASSISTANCE



SCN Lead Entities may support contracted social care service providers with technical assistance and training as needed, on topics such as:

Onboarding to and using the SCN IT platform

End-to-end care delivery approach, from screening to service delivery

Workflows for certain HRSN services and eligibility scenarios

Billing for screening and HRSN services

Cultural and linguistic responsiveness

NEXT STEPS AND RESOURCES FOR SERVICE 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
- **Share information with colleagues and partners** who may be interested in learning more or participating in an SCN
- **Share information with Medicaid Members** on services that may be available to them and direct them to the regional SCN **beginning in 2025**
- **Share input and feedback** with SCN Lead Entities and OHIP, to support overall program success during and beyond the demonstration period



[New York Social Care Networks Website](#)



[Social Care Networks: Introduction for HRSN Service 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

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
Hudson Valley	Hudson Valley Care Coalition, Inc.
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