MEMORANDUM

TO: All Social Care Network (SCN) Lead Entities and New York State Health Homes

FROM: New York State Department of Health's Office of Health Insurance Programs (OHIP) - Bureau of Adult Special Populations and Bureau of Social Care and Community Supports

DATE: July 11, 2025

RE: NYHER reimbursement for Health Homes delivering services as part of Social Care Networks (SCNs)

Introduction

The 23 Health Homes across New York State play a key role in ensuring that the State's Social Care Network program can reach and deliver health-related social needs (HRSN) services to eligible Medicaid members. SCN Lead Entities are strongly encouraged to partner with Health Homes in their region so that Health Homes may provide reimbursed Screening, Navigation, and Enhanced HRSN Services to both Health Home-enrolled members and other Medicaid members. This guidance applies to Health Homes, Care Management Agencies, and Care Coordination Organizations (CCOs).

Health Homes are a core partner in reaching Health Home-enrolled Medicaid members, who are an enhanced population eligible for HRSN services delivered by SCNs (including housing, nutrition, transportation, and care management services). In addition, given that care management provided by Health Homes is similar to Social Care Navigation within the SCN program, Health Homes and their care management partners are well positioned to serve as Social Care Navigators within SCNs for both Health Home-enrolled members and other Medicaid members.

Participating in SCN activities not only benefits Medicaid members but also offers an opportunity for Health Homes to unlock new funding streams. For example, a Health Home could generate between $35-40K+ in additional monthly revenue if they were to screen 500 members, provide navigation services to half of these members (250), and provide enhanced HRSN care management to 50 members.

Because the Health Home Comprehensive Assessment and SCN Enhanced Assessment both contain screening for health-related social needs and because both Health Homes and SCNs offer some level of care coordination, navigation, and care management, there is an opportunity to further define how Health Homes and SCNs can partner. This memo is

intended to clarify information included in the SCN Operations Manual on how Health Homes can be reimbursed for providing HRSN services, including Screening and Navigation. This memo also clarifies opportunities for Health Homes to receive capacity-building funds and work with SCNs to help scale up their ability to support members.

The memo contains the following sections:

I. Overview: Reimbursement across the SCN member journey

Health Homes (serving adults or children) that contract with SCN Lead Entities can be reimbursed via New York's 1115 waiver (NYHER) for the following activities. Health Homes can choose to participate in SCNs to conduct any of the activities below; Health Homes may do either Screening, Navigation, or Enhanced Care Management or choose to do all these activities.

NYHER reimbursement of Health Homes for activities across the member journey

Steps in SCN member journey and relevant fee schedule section *Definitions*[1]	Reimbursable via NYHER *Applies to Health Homes serving adults & children*		Fee schedule rate
	Medicaid Members enrolled in Health Homes	**Other Medicaid Members not enrolled in Health Homes**	
Screening (Service 0) *Time spent explaining the SCN program to a member, walking through the Screening with the member, obtaining consent, inputting the member's information and answers to Screening questions, and responding to the member's questions about next steps.*	**Can** be reimbursed via NYHER if following SCN guidelines	**Can** be reimbursed via NYHER	$17.50/15 min, up to $35 per Screening
Navigation to Existing Federal, State, and Local Services (Service 1.1) Assessment and c*onnection to existing services provided by the federal, state, or local programs.*	**Cannot** be reimbursed via NYHER	**Can** be reimbursed via NYHER	$17.50/15 min, up to $70 per event
Enhanced Population Eligibility Assessment (EA) (Services 1.2a) and Navigation to Enhanced HRSN Services (Service 1.2b) *Assessment of the enhanced population member's eligibility for NYHER-financed Enhanced HRSN Services conducted by a Social Care Navigator. Connection and referral to NYHER Enhanced HRSN Services.*	**Can** be reimbursed via NYHER	**Can** be reimbursed via NYHER	$17.50/15 min, up to $350 per month
Enhanced HRSN Care Management (Service 1.2b) *Care Management for members eligible for Enhanced HRSN Services includes referral management, follow-up, and Social Care Plan completion.*	**Can** be reimbursed via NYHER	**Can** be reimbursed via NYHER	

*Medicaid members not enrolled in Health Homes are covered if part of another Enhanced Population eligible to receive Enhanced HRSN Services

Note: Health Homes should continue to bill when a core service is provided (see Health Home Provider Manual Section 9.1.1 and any other DOH guidance which may be promulgated for minimum billing standards) and SCNs should continue to follow the billing guidance issued by DOH in the SCN Operations Manual and Data and IT Factsheet. There will be scenarios where Health Homes will bill for coordinating with the Social Care Navigators in the same way they would bill for coordinating with primary care and

[1] SCN Operations Manual, version 4

behavioral health providers, housing case managers, managed care plans, or others that are part of an individual's care team – detail follows in case example section.

II. Screening

Health Homes are encouraged to consider screening both their attributed Health Home-enrolled members and other Medicaid members and can receive time-based reimbursement for screening all members ($17.50 per 15-minute increment, up to $35/screening), consistent with the SCN regional fee schedule.

Time spent under screening includes the time spent explaining the SCN program to a member, walking through the screening with the member, obtaining consent, inputting the member's information and answers to screening questions, and responding to the member's questions about next steps. Health Homes currently screen members for HRSNs as part of a comprehensive assessment, but the Screening tool does not fully match the AHC Screening tool, which must be used to receive reimbursement via NYHER. In order to receive screening reimbursement under NYHER, Health Homes should:

- Ask the additional questions that are not included in the existing Screening tool (e.g., question 0 for consent, employment, education, demographic questions) to align with AHC SCN Screening tool and ensure a complete Screening.
- Complete Screening directly in the SCN IT platform or in an interoperable platform, working with a QE to ensure data quality standards are met and that the screening can be ingested into the SCN Program's data lake.

Consistent with all organizations conducting Screening, Health Homes should follow all requirements laid out in the SCN Operations Manual to receive reimbursement.

For Health Home members, the Health Home Medicaid rate should NOT be billed if the only service provided in the month is the completion of the AHC Screening tool. However, if the Health Home completes other assessment/Screening tools alongside the AHC Screening and/or completes follow-up on the AHC Screening for a core service, then billing the Health Home Medicaid rate is allowable for that month.

III. Navigation to Existing Federal, State, and Local Services

Members who are not eligible for Enhanced HRSN Services under the SCN program are navigated by Social Care Navigators to existing federal, state, and local services. Because

Health Homes already provide this kind of support for Health Home-enrolled members, they cannot receive NYHER reimbursement for navigating Health Home-enrolled members to existing services.

For example, a Health Home conducted an eligibility assessment of a Health Home member: The time spent on the Eligibility Assessment is reimbursable under Navigation to Enhanced HRSN Services. During the course of that eligibility assessment, the Navigator determined that the member required a referral to TANF. The Navigator should connect the member with TANF but should not bill time for this.

Given that Health Home-enrolled members are an enhanced population that is eligible for Enhanced HRSN Services, OHIP expects that Health Home-enrolled members will qualify for Navigation to Enhanced HRSN Services (outlined below), for which Health Homes can be reimbursed.

Medicaid members that are NOT enrolled in Health Home but are referred by the SCN can be navigated to existing resources and the Health Home can be reimbursed under Service 1.1. Navigation Services – Eligibility Assessment and Navigation to Existing Resources (Level 1). Per the SCN regional fee schedule, Health Homes may receive reimbursement for navigating other Medicaid members to existing services with reimbursement for time spent with each member at a rate of $17.50 per 15-minute increment, up to $70 per event.

IV. Navigation to Enhanced HRSN Services

Health Homes can be reimbursed for Navigation to Enhanced HRSN Services (nutrition, transportation, housing, and care management services) for both Health Home members and Medicaid members who are not enrolled in Health Homes. Per the SCN regional fee schedule, Health Homes receive time-based reimbursement of $17.50 per 15-minute increment, up to $350 per month for time spent:

- Conducting an Eligibility Assessment
- Creating a Social Care Plan for enhanced services
- Referring members to Enhanced HRSN Services
- Providing ongoing engagement with members receiving Enhanced HRSN Services
- Closing the loop on referrals to Enhanced HRSN Services

Health Homes should not bill for Enhanced HRSN Care Management Services for Health Home members not receiving Enhanced HRSN Service(s). Enhanced HRSN Care

Management Services for Health Home members should only be billed if a member is also receiving Enhanced HRSN Service(s).

OHIP considers Navigation to Enhanced HRSN Services incremental to—not duplicative of—services that Health Homes already provide to Health Home members. For example, a Health Home-based Navigator screens the member and identifies an unmet need for nutrition. The Navigator then conducts an Eligibility Assessment within the SCN IT Platform to determine which Enhanced HRSN Services the member is eligible for. Navigator develops a Social Care Plan in conjunction with the member and makes referrals to HRSN Service Providers listed in the IT Platform for Medically Tailored Meals and Nutrition Counseling. The Navigator continues to check-in with the member to ensure that services are meeting their needs. All the time the Navigator spent with the member on Screening, Navigation, and ongoing Care Management can be reimbursed through NYHER. In parallel, the Health Home should continue to use existing funding to provide other services to members.

The eligibility assessment, navigation, and referrals must take place directly in the SCN IT platform or in an interoperable platform, working with a QE to ensure data quality standards are met and that the screening can be ingested into the SCN Program's data lake (please note the assessment and navigation must be conducted directly in the SCN IT platform).

V. Enhanced HRSN Service Delivery

Health Homes contracted with a SCN can receive reimbursement for providing Enhanced HRSN Services to eligible members (nutrition, transportation, housing, and care management services). For a detailed list of services provided by the SCN program, see the SCN Operations Manual.

NYHER funding for HRSN services may not replace funding from other local, state, or federal programs.[2] Provided that Health Homes support members via the SCN workflow (e.g., members receiving services were screened, received an eligibility assessment, etc.), Health Homes may receive reimbursement through NYHER.

[2] New York State Dept. of Health memo "Reimbursement of HRSN service providers for services delivered via the SCN program"

VI. Capacity Building Funds

SCN Lead Entities distribute capacity-building funds to organizations within their Networks to enable organizations to provide high-quality and member-centric HRSN services and establish financially and operationally sustainable, self-innovating ecosystems that will continue to deliver services after the end of the NYHER 1115 Waiver amendment period (see additional details in the SCN Operations Manual).

Health Homes and Care Coordination Organizations (CCOs) may receive capacity building funds if all the following criteria are met:

- They have a 501(c)(3) or 501(c)(4) status; and either of the following:
    a. Have a separate line of business that will provide HRSN Services which is operated in a separate division or unit from the portion of the business that is billing for Health Home Services; the line of business providing HRSN services must have separate books and records, staff, and management from the Health Homes business or are contracted with a SCN to receive referrals outside of the Health Home Members from the SCN ; or
    b. Health Homes and CCOs may receive capacity-building funds to hire, onboard, provide equipment to, and train full or part-time staff (Social Care Navigators) if they provide screening, navigation and enhanced care management to Health Home/CCO members and non-Health Home members referred from the SCN that meet the enhanced (level 2) member criteria.

In general, Health Homes and CCOs may apply for capacity building funds on behalf of the separate line of business providing HRSN Services. The line of business that receives and uses the funds must use the funds towards delivering HRSN Services to members. This includes Health Homes run through FQHCs, behavioral health clinics, and health systems as long as the Health Home meets the above criteria.

In addition, care management agencies may receive capacity funding if they have a 501(c)(3) or 501(c)(4) status.

VII. Health Home Care Manager and Social Care Network Navigator Collaboration

Health Home Care Managers and Social Care Network navigators are encouraged to coordinate for shared members. This is a significant opportunity to allow for robust care coordination, alleviate some burden from Health Home Care Managers, get members access to the Enhanced HRSN Services needed, and allow for step-up and step-down comprehensive support as individuals change acuity levels. Ideally:

- **Connection to SCNs**: Health Home Care Managers complete referrals to the SCN for any member they identify that has an unaddressed HRSN and is interested in services. Health Home Care Managers also continue to coordinate needs to address that need until the HRSN services pick up, as well as to coordinate additional HRSN-related services that are not being provided through the SCN. Health Home Care Managers are encouraged to make and document best efforts to coordinate with the SCN to identify a) shared members and b) which services are being received. Health Home Care Plans are encouraged to include SCN coordination as part of the overall plan to address any HRSNs, and the SCN should be included on the DOH 5055 if the member is receiving HRSN services.
- **Screening and Navigation**: During the Screening and Navigation processes, if Social Care Navigators speak with somebody who is eligible for and in need of Health Home services, they should identify whether an individual is already connected to a Health Home.
  - **If already connected to a Health Home**, the Social Care Navigator should make best efforts to reach out to the Health Home to make them aware of the SCN involvement and any HRSN needs and/or services that they are eligible for.
  - **If not already connected to a Health Home**, the Social Care Navigator should complete a referral. For members that are only eligible for Screening and Navigation, this will allow the member to get more holistic support in accessing necessary local, state and federal services. For members eligible for Enhanced HRSN Services, the Health Home Care Managers and Social Care Navigator should coordinate.
- **Transitions of Care**:
  - Health Home Care Managers should help support transitions for members when their Enhanced HRSN Services are ending (e.g., conclusion of 6 months of rental support). Social Care Navigators should make best efforts to reach out to the Health Home Care Managers to notify them when services are ending and to coordinate a transition plan.
  - The Social Care Navigators and HRSN Service Providers may support step-down for individuals who are ready to graduate from or otherwise needs to be disenrolled from the Health Home program. Health Home Care Managers

should coordinate with the existing Social Care Navigator (if there is one) or make a referral to the SCN to support any HRSNs that exist when the member is in the process of being disenrolled.

For additional questions on the SCN program, please reach out to SDH@health.ny.gov. or visit the New York State Department of Health website.