New York Health Equity Reform (NYHER) 1115 Waiver Program: Social Care Networks (SCN)

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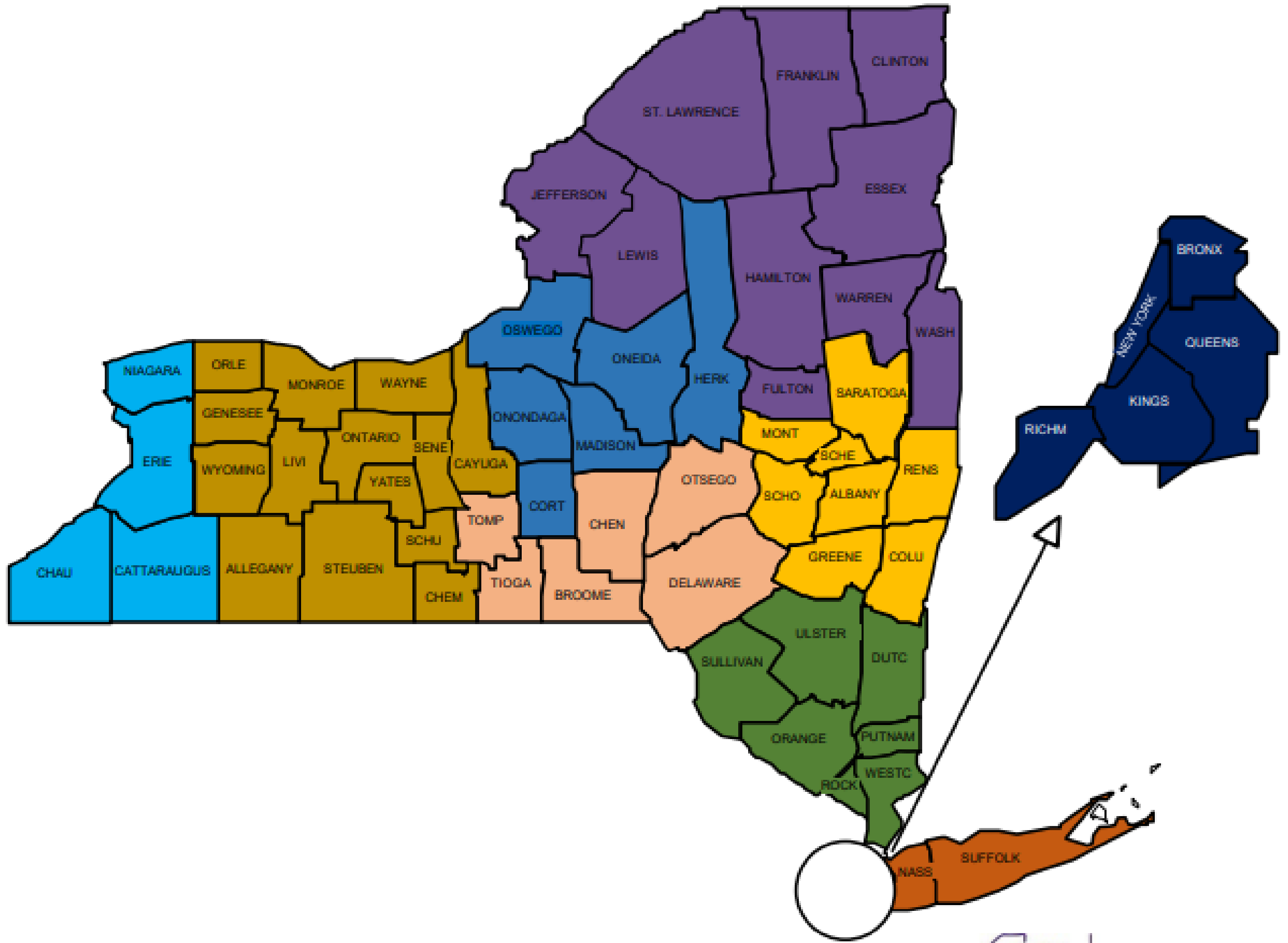
Overview SCN Responsibilities

Organization	• Establish and maintain a governing body and executive leadership team that reflects and understands the unique needs of the region.
Contracting	• Contract with the Managed Care Organizations of each region to facilitate payments and validate eligible members.
Fiscal Administration	• Receive and manage a PMPM per Medicaid Managed Care Member. • Bill Fee For Service for members that are Fee For Service. • Pay CBOs for services rendered in a timely manner.
IT Platform/Data and Reporting	• Contract with Social Care IT platform to manage referrals and ensure connectivity. • Connect to the SHIN-NY and report on screening and services through standardized codes.
CBO Network and Capacity Building	• Formally organize and coordinate contracted network of CBOs to deliver social care services. • Ensure network adequacy and build CBO capacity to participate in the network.
Regional Partnerships	• Collaborate with partners within the regional ecosystem to screen members for HRSN. • Validate eligibility, navigate to appropriate services, manage and close the loop on referrals.

SCN Coverage Areas

Social Care Network (SCN) Regions	Counties
Region 1: Capital Region	Albany, Columbia, Greene, Rensselaer, Montgomery, Saratoga, Schenectady, and Schoharie
Region 2: Western NY	Cattaraugus, Chautauqua, Erie, Niagara
Region 3: Hudson Valley	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Region 4: New York City	Bronx, Kings, Queens, New York, Richmond
Region 5: Finger Lakes Region	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Region 6: Southern Tier	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
Region 7: Central New York	Cortland, Herkimer, Madison, Oneida, Onondaga, and Oswego
Region 8: Long Island	Nassau, Suffolk
Region 9: North Country	Clinton, Essex, Franklin, Fulton, Hamilton, Jefferson, St. Lawrence, Lewis, Warren, and Washington



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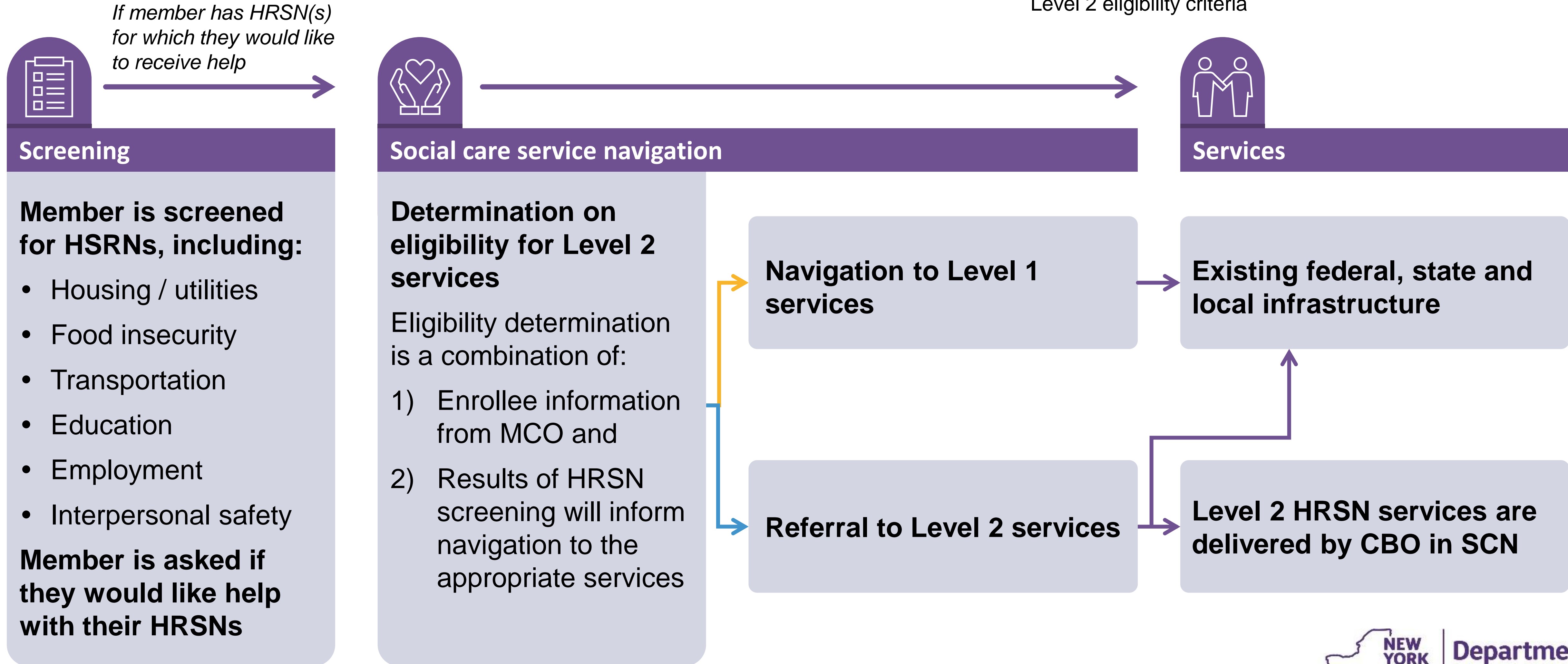
HRSN Screening

- SCN lead entities will **coordinate** with CBOs in their network and other partners in the regional ecosystem (e.g., healthcare providers, care management providers, MCO) **to screen Medicaid members annually.**
- All Medicaid members will be screened using a New York State-standardized version of the **Accountable Health Communities (AHC) screening tool** to assess member needs across a range of HRSN domains (**i.e., housing and utilities, food security, transportation, employment, education, and interpersonal safety).**
- SCN Lead entities will be accountable for:
    - Ensuring sufficient **capacity** in their region(s) to screen **all Medicaid members**,
    - Tracking the results of HRSN screenings through their data and IT platforms to ensure that members with identified needs receive timely **navigation to social care services.**

Service Navigation

- Following HRSN screening, Medicaid members will be **navigated to social care services** that most appropriately meet their needs.
- SCN lead entities will be accountable for ensuring that **eligible members are navigated** to appropriate social care services delivered by CBOs in their network.
- Using the SCN’s data and IT platform, SCN lead entities will be expected to **“close the loop”** on social care services covered by the 1115 waiver. SCN lead entities will be instrumental in ensuring a seamless and efficient member experience from screening to service provision.
- **All referral data will flow through the SCN’s data and IT platform**, supported by the Statewide Health Information Network-New York (SHIN-NY).

Member Journey Map



Populations Eligible for Navigation to Enhanced HRSN Services

Populations Eligible for Navigation	If a member **does not meet the criteria for Enhanced HRSN services**, they will receive **navigation to pre-existing state, federal, and local programs** to address HRSN.
Populations Eligible for Enhanced HRSN Services	If a member is enrolled **in Medicaid Managed Care + screens positive** for an unmet HRSN + meets one of the following criteria: • **Medicaid High Utilizer** (defined by Emergency Department, Inpatient, or Medicaid spend or transitioning from an institutional setting) • **Individuals enrolled in a designated** Health Home which currently includes HIV/AIDS, Serious Mental Illness, Sickle Cell Disease, Serious Emotional Disturbance or Complex Trauma (children only), or those with two or more chronic conditions (e.g., diabetes and chronic obstructive pulmonary disease) • **Pregnant Persons / up to 12 months Postpartum** • **Post-Release Criminal Justice-Involved Population** with serious chronic conditions, SUD, or chronic Hepatitis-C • **Juvenile justice involved, foster care youth, and those under kinship care** • **Children under the age of 6** • **Children under the age of 18 with one or more chronic condition** • **Substance Use Disorder** • **Intellectual or Developmental Disability (I/DD)** • **Serious Mental Illness**

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Social Care Network HRSN Services

Standardized HRSN Screening

- Screening Medicaid Members using questions from the CMS Accountable Health Communities HRSN Screening Tool and collecting key demographic data

Housing Supports

- Navigation
- Community transitional services
- Rent/utilities
- Pre-tenancy and tenancy sustaining services
- Home remediation
- Home accessibility and safety modifications
- Medical respite

Nutrition

- Nutritional counseling and classes
- Medically tailored or clinically appropriate home-delivered meals
- Food prescriptions
- Fresh produce and nonperishable groceries
- Cooking supplies, such as pots, pans, utensils, microwaves, etc.

Transportation

- Reimbursement for HRSN public and private transportation to connect to HRSN services and HRSN case management activities

Case Management

- Case management, outreach, referral management, and education, including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees
- Connection to clinical case management
- Connection to employment, education, childcare, and interpersonal violence resources
- Follow-up after services and linkages

Role of Entities in Social Care Network (SCN) Ecosystem

Community Based Organizations (CBOs):

- Contracted as part of the SCN and may also participate in the screening of Medicaid members for HRSN and service navigation, and care management upon meeting screening criteria.
- Connect to the SCN technology platform.

Managed Care Organizations (MCOs):

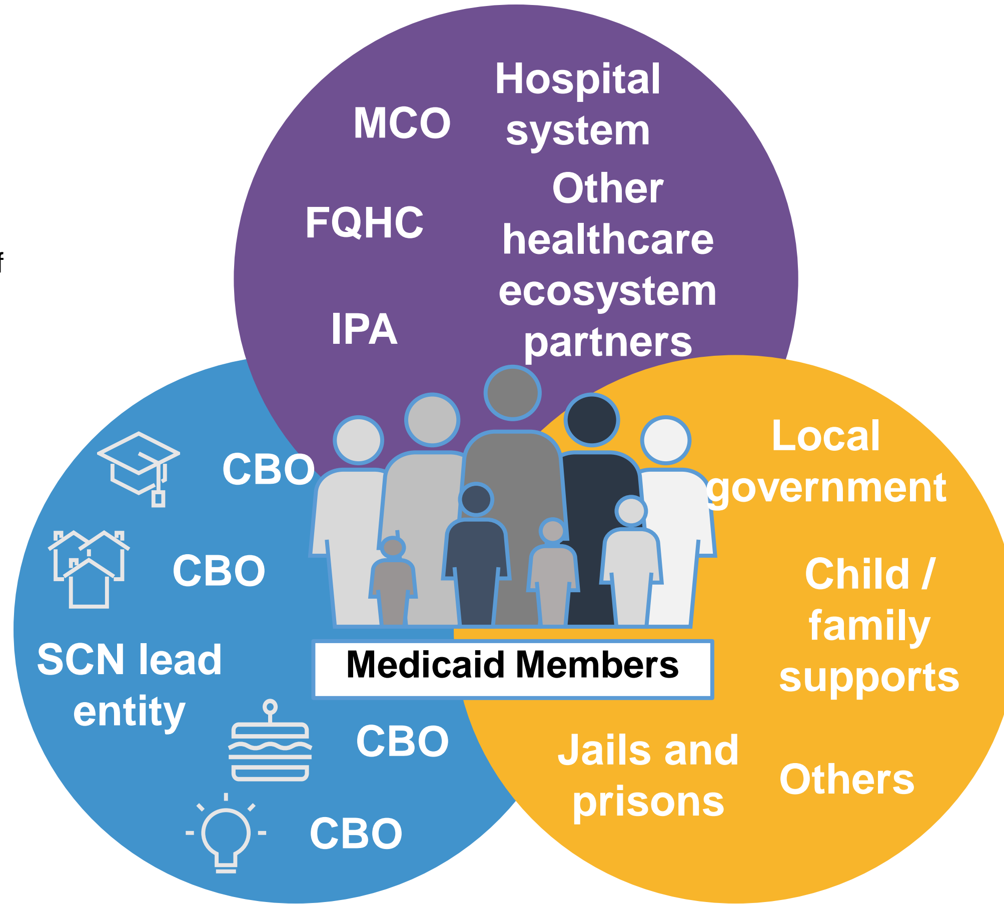
- Contract with SCNs and will be responsible for the allocation of per-member-per month (PMPM) payments to SCN lead entities.
- Responsible for providing information that will help validate member eligibility for social care services delivered by the SCN.
- Receives social care claims from the SCN and submits social care encounters to State.

Providers(Health, Behavioral Health, & Other Care Management):

- Continue to deliver healthcare to Medicaid members in their region.
- Providers with access to the SCN data and IT platform may also support with social care service navigation (screening members for HRSNs, validating member eligibility, and referring to services).

Social Care Network Lead Entities (SCNs):

- Establish a technology platform to send and receives member information and eligibility for Level 2 services, screening, referral, social case management, and member consent/attestation.
- Via the Qualified Entities (QEs), connect to SHIN-NY for seamless information sharing.



Social care network (SCN)
Healthcare ecosystem partners
Other ecosystem partners

Impact of future state system on Medicaid members

Scaled delivery of social care services and **improved access** for Medicaid members

Reliable and timely referral of members to social care services

Seamless tracking of members needs to streamline and close loop on referrals to social care services

Improved and increased **collaboration between social care services and other partners in regional ecosystem** (e.g., healthcare providers, care management providers, MCOs, others)

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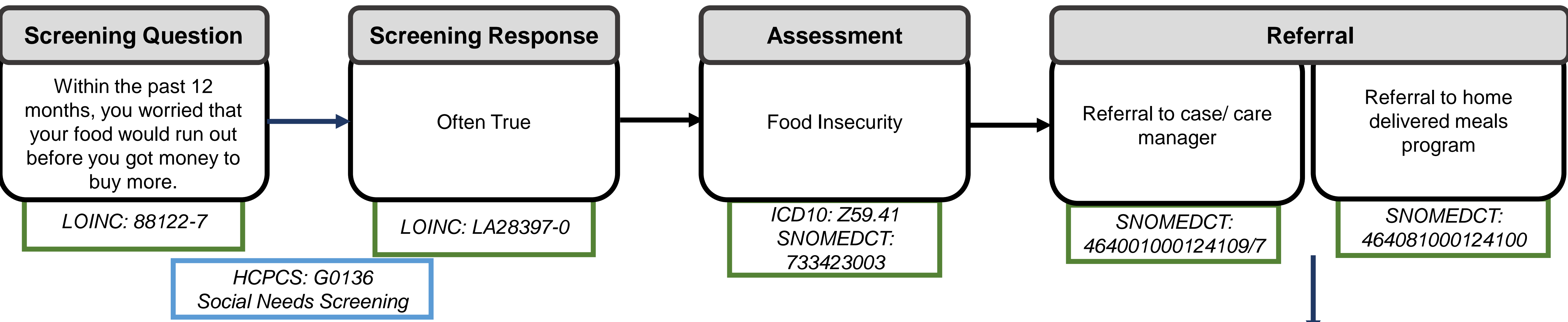
Example Mapping: Screening to HRSN Service



Provision of Service

Home delivered meals, including preparation; per meal	Provision of home-delivered meals
HCPCS: S5170	*SNOMEDCT: 464421000124107*

Key

- Green box: Social Care Codes (sent to SHIN-NY Data Lake)
- Blue box: Billing Codes (claims/encounters sent to MCOs)

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Network data/IT architecture

Stakeholders
Interoperable data systems
Optional interoperable data systems
Data
Data flow

Preliminary

NYS DOH – OHIP/HERO

MDW

State and local agencies
TBD whether other agencies will have access to the SCN platform data

Healthcare providers
SCN IT platform
Electronic health records

Medicaid Managed Care Organizations
SCN IT platform
Population health, member services, claims systems

Bi-directional exchange of enrollee and eligibility info

Encounter data

Data storage

SCN quarterly performance reports

Social care claims

Qualified Entities
Regional HIEs (SHIN-NY)

Encounter intake system / OSDS[3]

New York eHealth Collaborative
SCN data lake

Community-based organizations[1,2]
SCN IT platform
SCN lead entity
Social Care Network (SCN)

Bi-directional exchange of data on: Member information and eligibility for Level 2 services, screening, referral, and social case mgmt., member consent/attestation

1. Some CBOs may not formally participate in the SCN
2. If CBO does not have access and/or ability to input data directly in SCN IT platform in early stages of implementation, the SCN lead entity will be required to manually include screening information from CBOs
3. All-payer claims database (APCD)

HRSN Funds Flow Overview

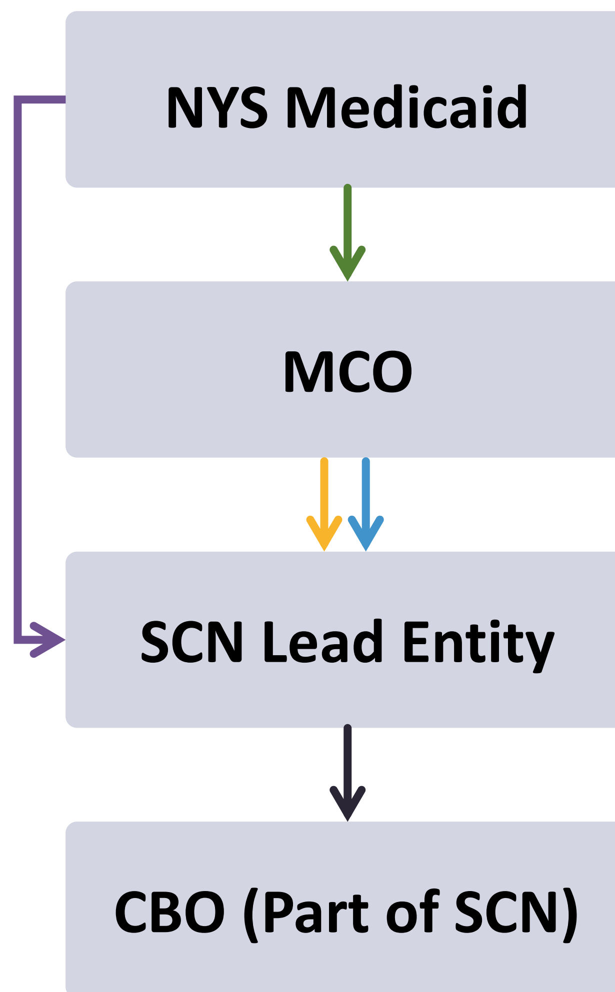
Infrastructure Funds: State pays infrastructure funds to SCN per terms of the SCN RFA.

MCO Payments: State pays standard managed care PMPM plus HRSN PMPM to MCOs.

HRSN Screening and Services Payments: MCOs pay PMPM to SCNs for HRSN services, according to State Directed Payment (SDP) terms.

Bonus Performance-Based Payments: MCOs make bonus payments to SCNs based on performance metrics according to the terms of the SDP.

Payments for Services Delivered: SCNs make fee-for-service (FFS) payments to CBOs for HRSN services delivered by CBOs, according to State fee schedule.



HRSN Funds Flow Evolution

- HRSN PMPM will be fully reconciled to the services delivered in the early stages; over time, this will transition to risk based for the MCO-SCN transactions while the CBO continues to be reimbursed on a FFS basis
- As HRSN screening data is collected on all Medicaid members, social care risk adjustment will be incorporated
- This infrastructure is expected to remain after the end of the waiver period with HRSN payments being incorporated into VBP arrangements

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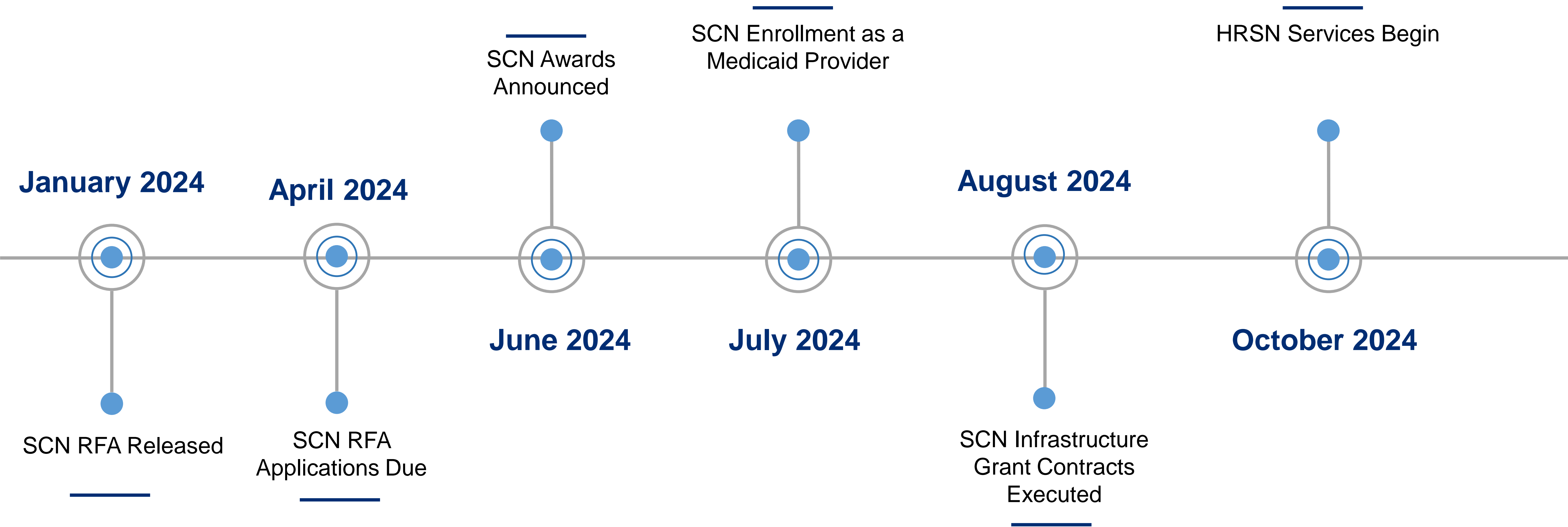
SCN Timeline



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Appendix

Accountable Health Care Health Related Social Needs Screening Questions		
Housing/ Utilities		
1. What is your living situation today?	☐ I have a steady place to live ☐ I have a place to live today, but I am worried about losing it in the future ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	
2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	☐ Pests such as bugs, ants, or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat	☐ Oven or stove not working ☐ Smoke detectors missing or not working ☐ Water leaks ☐ None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	☐ Yes ☐ No ☐ Already shut off	
Food Security		
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	☐ Often true ☐ Sometimes true ☐ Never true	
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	☐ Often true ☐ Sometimes true ☐ Never true	
Transportation		
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	☐ Yes ☐ No	

AHC HRSN Screening Tool (Continued)

Employment	
7. Do you want help finding or keeping work or a job?	☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	☐ Yes ☐ No
Interpersonal Safety **Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.**	A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe
9. How often does anyone, including family and friends, physically hurt you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
12. How often does anyone, including family and friends, scream or curse at you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)