Staten Island
Performing Provider System

Staten Island Social Care Network Waiver 1115

https://statenislandpps.org/social-care-network/

(917) 830-1140

SIPPS-ContactUs@northwell.edu

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

VISION AND GOALS FOR SCN PROGRAM

Background

The mission of New York State is to protect and promote health for all, building on a foundation of health equity. In New York and nationally, there is growing recognition that fully achieving health for all requires a focus not only on physical and behavioral health, but also on HRSNs.

It is now widely acknowledged that addressing social needs such as food insecurity, housing instability, and lack of transportation improves health and lowers health care costs. To ensure that these needs are consistently addressed for New York's Medicaid Members, our state needs a coordinated infrastructure and set of processes through which people's unmet HRSNs can be identified, people can be connected to services to address those needs, and the organizations who provide those services can be paid.

What are Social Care Networks?

To meet that need, OHIP has established regional SCNs across the state to ensure that the HRSNs of Medicaid Members are more consistently identified and addressed.

Each SCN is comprised of a Lead Entity who contracts and coordinates with a network of CBOs and other organizations providing HRSN services as well as other providers (inclusive of behavioral health and primary care providers). Together, each Network will be responsible for ensuring that this is a seamless, consistent end-to-end process in their region for HRSN Screening, Navigation, and delivery of HRSN services. This will require close collaboration within each Network, as well as shared data and technology. All entities contracted into the SCN for Screening, Navigation, and/or service delivery are collectively referred to as HRSN service providers throughout this Manual.

NEW YORK STATE | Department of Health

OVERVIEW OF SCN PROGRAM DESIGN

Core responsibilities of SCN Lead Entities

SCN Lead Entities are regional organizations charged with building strong Social Care Networks of contracted organizations to collectively ensure consistent Screening, Navigation, and delivery of HRSN Services for the Medicaid Members in their area.

The core responsibilities of SCN Lead Entities include:

Build and maintain a comprehensive Social Care Network of contracted organizations that collectively screen all Medicaid members in their region for HRSNs, navigate Members with HRSNs to appropriate services, provide high-quality HRSN services, and provide data and reporting on these activities

Enroll in the New York State Medicaid Program as a Medicaid billing social care provider. SCN Lead Entities will be Medicaid billing social care providers. They will be re-designated by NYS every five years and must also revalidate with the Medicaid program every five years. (*See SCN Medicaid Billing Social Care Provider Designation and Enrollment for more information*)

Ensure more intensive coordination of HRSN services for Medicaid Managed Care Members eligible for Enhanced HRSN Services. This includes individuals who are Medicaid High Utilizers, individuals enrolled in a NYS Health Home, pregnant and postpartum persons, criminal justice-involved populations with chronic or mental health conditions, high risk children under the age of 18, and people living with Intellectual or Developmental Disabilities, Serious Mental Illness, or Substance Use Disorders (*For additional guidance on eligible Members, see Medicaid Member Eligibility*)

Create a more accessible customer experience for Medicaid Members seeking HRSN services through Social Care Navigation and Closed Loop Referrals

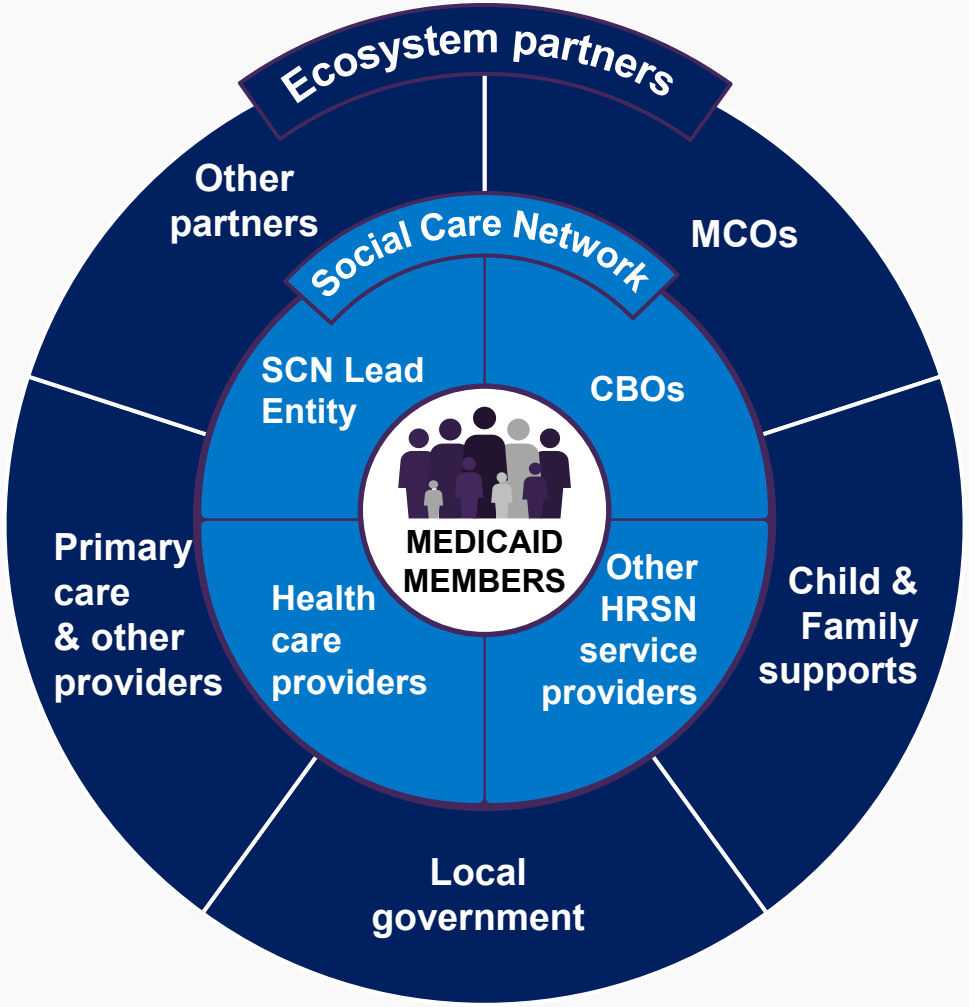
Build the capacity of CBOs to provide high-quality HRSN services and to manage new or increased administrative responsibilities through capability-building and reliable funding streams

Establish financially and operationally sustainable, self-innovating ecosystems that will continue to deliver services after the end of the NYHER 1115 Waiver amendment period

Promote more equitable delivery of HRSN services and address the health, racial, ethnic, socioeconomic, and geographic disparities in existing access and quality

NEW YORK STATE | Department of Health

OVERVIEW OF SOCIAL CARE NETWORKS



Regional Social Care Networks connect **local 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**

NEW YORK STATE | Department of Health

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

OVERVIEW OF SOCIAL CARE NETWORKS

SCNs connect **community-based organizations, providers,** and **other partners** to provide screening, navigation, and delivery of health-related social need (HRSN) services to New York Medicaid members

Services available through SCNs include:

- Screening for unmet health related social needs
- Navigation to services
- Food and nutrition services
- Housing supports
- Transportation

NEW YORK STATE | Department of Health

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**

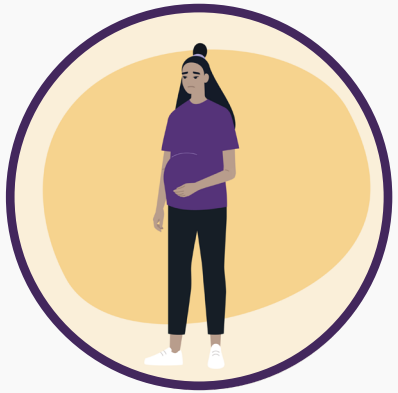
Facilitate sustainable Medicaid **reimbursement** for community-based services that improve health

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

NEW YORK STATE | Department of Health

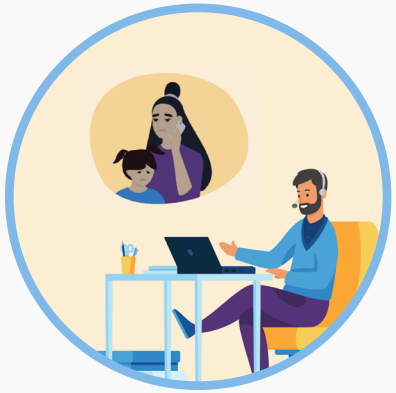
SOURCE: Medicaid Section 1115(a) Waiver - New York State Medicaid Redesign NYHER Amendment. January 9, 2024

THE MEMBER'S SCN JOURNEY: AN ILLUSTRATIVE EXAMPLE



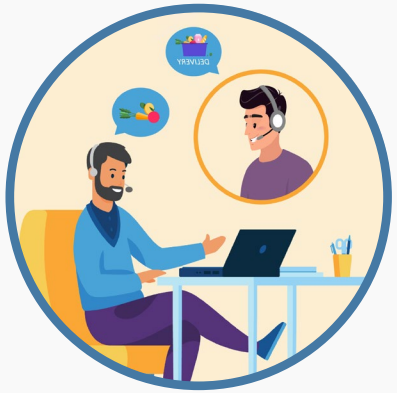
1

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 calls her regional SCN to see if she qualifies for help. The SCN Navigator screens Dani to identify her needs and verifies that she 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. Her SCN Navigator also connects her to the WIC Program.

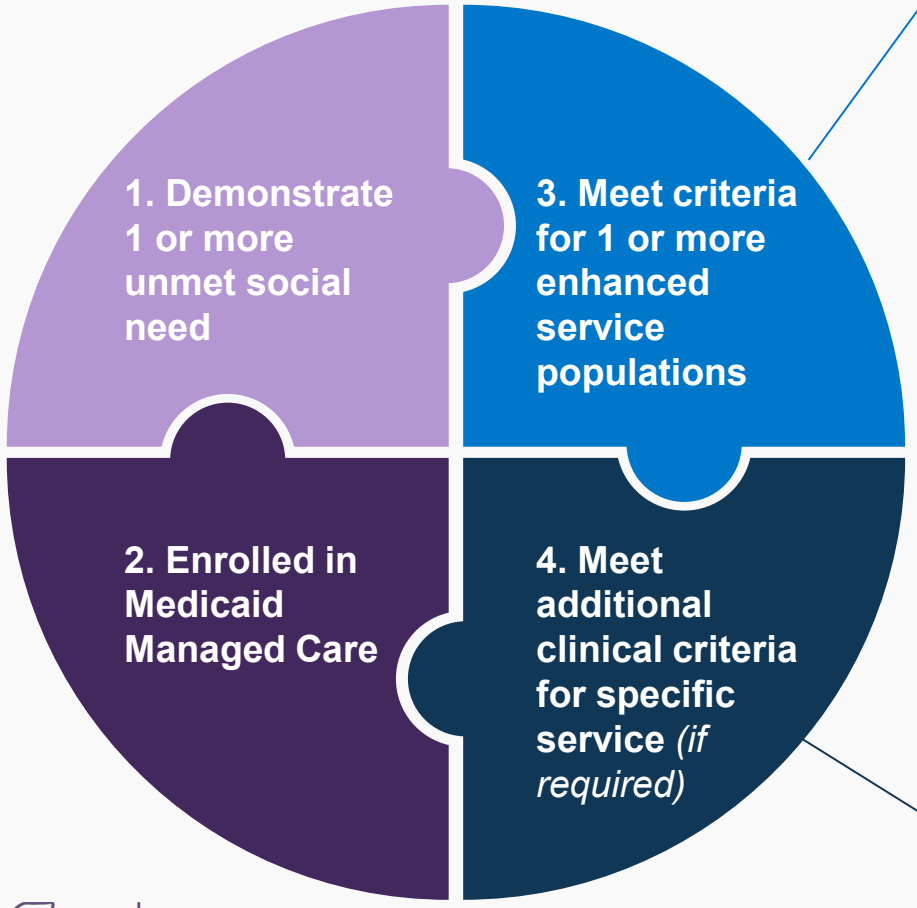
6

Dani remains connected to a network of social care providers in her community that she can access for assistance in the future

NEW YORK STATE | Department of Health

ELIGIBILITY FOR ENHANCED 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)
- Youth in care (e.g., foster care, juvenile justice, kinship care)
- Children under six who are at high risk and children under 18 with chronic health conditions
- 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., asthma, physical disability)

NEW YORK STATE | Department of Health

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

MEMBER EXPERIENCE ACROSS SCREENING, ELIGIBILITY ASSESSMENT, NAVIGATION

	Screening	Social Care Navigation	HRSN Services
What will the member experience?	Member is comprehensively screened for HRSNs using **standardized Screening tool that assesses their unmet needs,** whether they would like to receive HRSN services, and collects their basic contact information. If the Member screens positive and the screening entity is not a Social Care Navigator, Member will be informed that **they will be rapidly contacted by the SCN** to receive navigation to services.	Either during same encounter as Screening or following up on another entity's Screening, the Social Care Navigator **determines Member's eligibility for Enhanced HRSN Services** using information provided by: • the Member's MCO • the Member's HRSN Screening results • the Member or Member's provider, if needed The Social Care Navigator **navigates a Member to relevant HRSN Services.**	Member found to be eligible for Enhanced HRSN Services is **referred to an HRSN service provider.** Member found to not be eligible for Enhanced HRSN Services **is navigated to** other relevant federal, state, and local programs. At any point, Member can **engage with their Social Care Navigator** to discuss their evolving needs
Which entities in the SCN will do this?	SCN Lead Entity Entities within the Network	SCN Lead Entity Entities within the Network	SCN Lead Entity Entities within the Network
Which entities outside of the SCN can do this?	Healthcare providers Care management providers MCOs	MCOs	Federal, state, and local programs

NEW YORK STATE | Department of Health

ENHANCED HRSN SERVICES

Enhanced HRSN Services

Housing Supports

- Housing transition and navigation services
- Community transitional services
- Rent/utilities
- Pre-tenancy and tenancy sustaining services
- Home remediation
- Asthma 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 nonperishables (i.e., pantry stocking)
- Cooking supplies, (kitchenware, microwave, refrigerator)

Transportation

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

Care Management

- Care management, outreach, referral, and education, including linkages to other state and federal programs
- Connection to clinical case management
- Connection to childcare employment, education, interpersonal violence resources

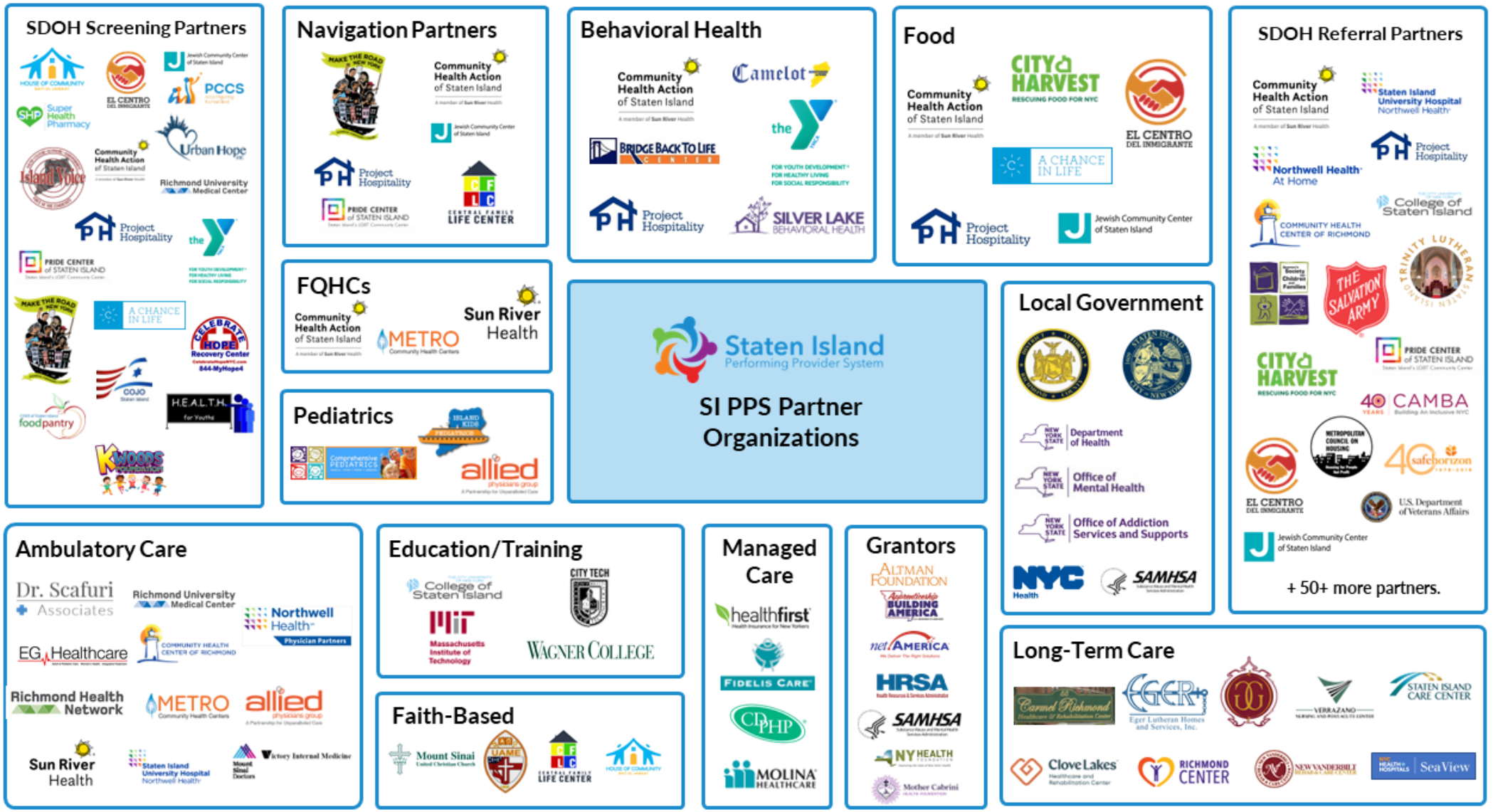
NEW YORK STATE | Department of Health

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.

NEW YORK STATE | Department of Health



Enrolling in the SCN Network

- *Requirements of enrolling in the SCN*
  - *Technology connections*
  - *Screening tools*
  - *Use of NYS approved AHC HRSN screening questions either:*
    - *via SCN IT Platform: Channels Option B*
    - *OR via EHR: Channels Option C*

	Options in NYS Attestation	**Interpretation** Practice has established a workflow to…
A	Connect patients to the regional SCN(s) (for Medicaid members) via referral provided to the patient	• Refer patients directly to the SCN for screening and other services (e.g. online web portal, SCN QR code, SCN telephone number).
B	Connect directly with the SCNs' platform to submit Accountable Health Communities Health Related Social Needs (HRSN) screenings and referrals for Medicaid members	• Actively screen and provide services to Medicaid patients as an enrolled organization with the SCN. • Includes screening patients at practice using the NYS HRSN screening tool (possibly in EHR and transmitted to SCN through Health Information Exchange or using community resource platform, e.g., UniteUs, FindHelp).
C	Connect with regional SCNs in another agreed upon way	• Screen patients and send results to the SCN through the RHIO, but do not use the SCN's screening tool (and not receive payment for in-practice screening).

ADDITIONAL RESOURCES

- New York 1115 Waiver Website
- Current Special Terms and Conditions
- New York Social Care Networks Website
- Career Pathways Training (CPT) Program Website
- Subscribe to MRT Listserv

For further information on the 1115 waiver, please contact us at: 1115waivers@health.ny.gov.

Thank you!

Visit our website: statenislandpps.org