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New York Health Equity Reform (NYHER) 1115 Waiver Program

New York Association on Independent Living

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JUNE 16,2025

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

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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 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 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**

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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 Equity Alliance 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

SCN PROGRAM UPDATE

Progress to date

- ☑ **9 regional SCN Lead Entities** continue to grow – contracting with **community-based organizations (CBOs) and physical and behavioral health providers**
- ☑ **Medicaid members** are receiving health-related social needs (HRSN) **screening, navigation, and services** across the state
- ☑ SCNs are using technology to enable and automate workflows, including **allowing providers to more easily attest to required clinical criteria** for members' access to services

Current priorities

- SCNs continuing to **contract with and onboard** CBOs and providers, including behavioral health
- SCNs **building navigator capacity** to meet growing member engagement
- SCNs and MCOs **expanding outreach and engaging members** in screening, referral, and service delivery
- **Continuously improving** program operations

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

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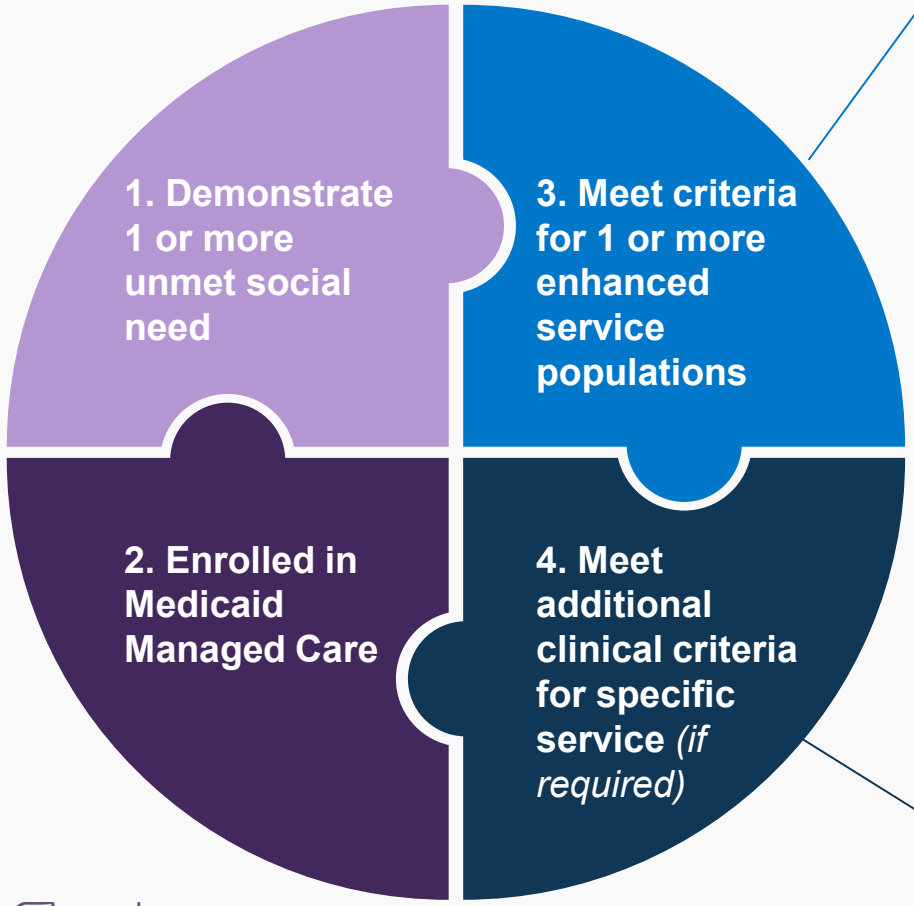
WHO IS ELIGIBLE FOR SERVICES?

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 – 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)

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

HEALTH-RELATED SOCIAL NEEDS SERVICES PROVIDED BY THE SCN

Enhanced HRSN services

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

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

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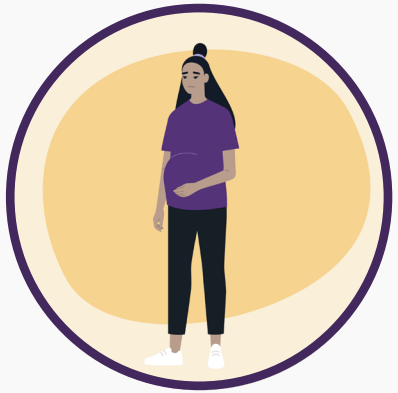
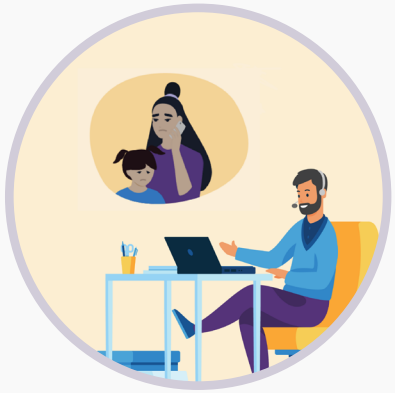
1. Members can be navigated to enhanced services by SCN Social Care Navigators or providers.

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

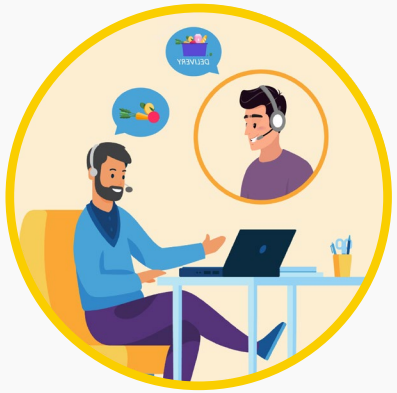
THE MEMBER'S SCN JOURNEY: AN ILLUSTRATIVE EXAMPLE



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

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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

AGENDA

Overview of Social Care Networks

How the Social Care Network program works

Role of HRSN service providers and how to get involved

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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)

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APPROACH TO HRSN SCREENING

Members will be screened using twelve questions from the **Accountable Health Communities (AHC) HRSN Screening tool**[1]

State's goal is for Medicaid Members to receive a screening **annually or after a major live 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

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11. The AHC HRSN Screening tool consists for 12 questions spanning six HRSN domains: housing and utilities, food security, transportation, employment, education, and interpersonal safety.

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

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)

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REIMBURSEMENT AND FUNDING

To receive reimbursement, HRSN service providers must:

- ☑ Do ***at least one*** of the following:
  - Screen Members using the AHC HRSN Screening tool[1]
  - 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

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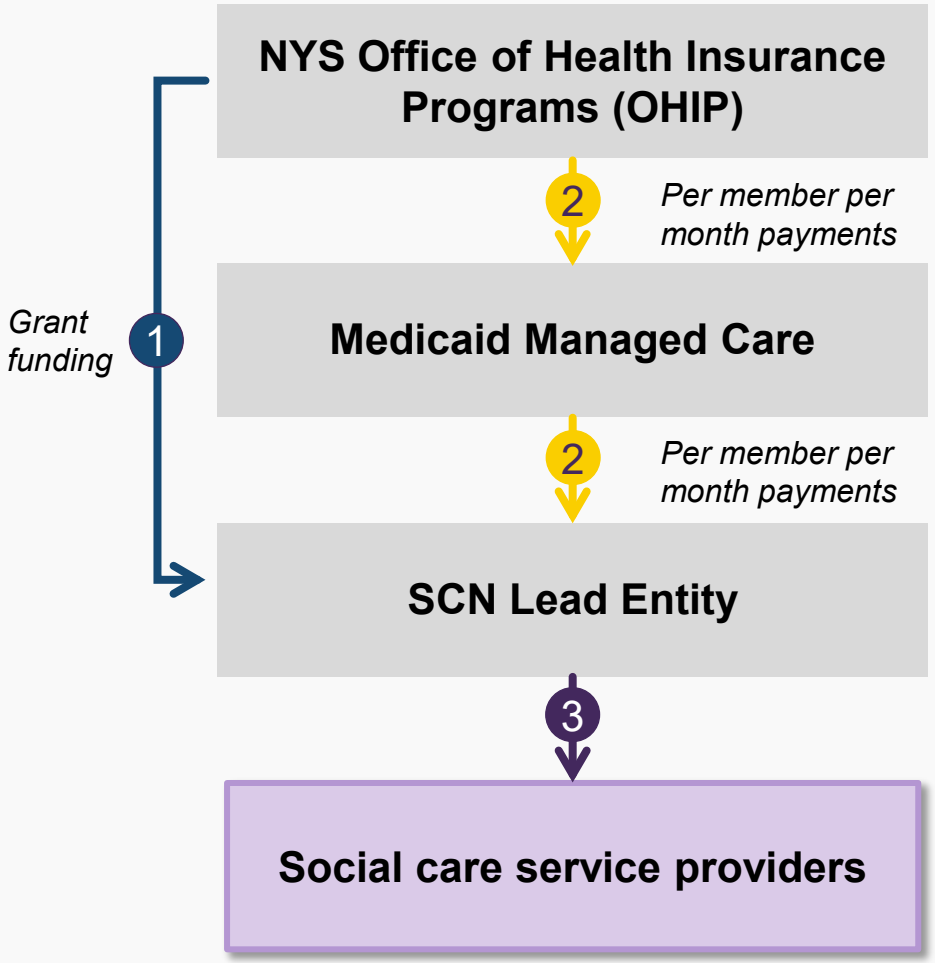
1. In order to be reimbursed for screening via the SCN Program, screenings must: use the standardized tool, be complete, be entered into the SCN IT Platform or a Platform that can share data with the SCN IT Platform, be the Member's annual screen or a verified rescreen, and involve a Member 1:1 interaction. Please see details in the SCN Operations Manual, section Reimbursement for Screening

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

SCN PAYMENT FOR SERVICE PROVIDERS



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

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?

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Sources: Association of State and Territorial Health Officials, Braiding and Layering Funding to Address the Social Determinants of Health; Center for Health Care Strategies, Braiding Medicaid Funds to Support Person Centered Care: Lessons from Medi-Cal, August 2024

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

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

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 the Social Care Networks programs, email SDH@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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