Social Care Networks (SCN): Introduction for Health Care Providers

As of December 2024

NEW YORK STATE | Department of Health Medicaid

Introduction

The mission of New York State is to protect and promote health for all, building on a foundation of health equity. Achieving this mission requires a focus not only on physical and behavioral health but also on health-related social needs (HRSNs). It is now widely acknowledged that addressing social needs such as food insecurity, housing instability, and lack of transportation can improve health outcomes.

The New York Health Equity Reform (NYHER) 1115 Waiver Demonstration established regional Social Care Networks to help ensure these needs are met for individuals and families who are Medicaid Members. The role of Social Care Networks (SCNs) is to identify Member's unmet social needs, connect Members to HRSN services, and sustainably reimburse organizations screening Members, navigating Members to services, and providing HRSN services.

SCNs include a range of HRSN service providers, including community-based organizations (CBOs) and other partners (e.g., regional non-profits), alongside health care providers.

This guide is for health care providers (including behavioral health providers). It provides an overview of the SCN program and answers common questions such as how health care providers can get involved, and expectations of participating in a SCN. Providers are encouraged to contact the SCN Lead Entity in their region for more information and operational guidance.

What this guide is	What this guide is not
✓ An introduction to SCNs for health care providers who see patients who are Medicaid Members ✓ Overview information that applies to the SCN program across regions	× A detailed operations manual to guide all aspects of participation in SCNs × Nuanced information specific to each region *Contact your regional SCN Lead Entity for more operational guidance and tailored information for your context*

Key terms

- **Health-related social needs (HRSNs):** Social and economic needs that can impact a person's health and well-being. Examples include lack of stable or affordable housing, lack of access to healthy food, lack of access to transportation, financial strain and/or unemployment, and personal safety.

- **HRSN service providers:** Organizations that provide services to meet individual needs around food, housing, transportation, and other social and/or economic needs. These can include local community-based organizations, non-profit organizations, government entities, health care providers, and private sector entities. In New York State, HRSN Service Providers also refers to entities that contract with a SCN to deliver a specific set of services to qualifying Medicaid Managed Care members and may be reimbursed for those services via the NYHER 1115 Waiver Demonstration.

- **Health care providers:** Organizations that provide health care services to individuals including primary care providers, behavioral health providers, Federally Qualified Health Centers (FQHCs), health homes, health systems / hospital systems, etc. Health care providers will be key ecosystem partners in the SCN program, with an objective of better integration of health care and social care through stakeholder convening and a shared data / IT layer.

- **Social Care Network (SCN):** A network comprised of HRSN service providers, Medicaid managed care organizations (MCOs), health care providers, and other organizations that contract with an SCN Leady Entity and may be reimbursed for services authorized by the 1115 Waiver.

- **Enhanced HRSN services:** Services that help meet members' HRSNs, can improve health outcomes, and are reimbursable for qualifying members via SCNs.

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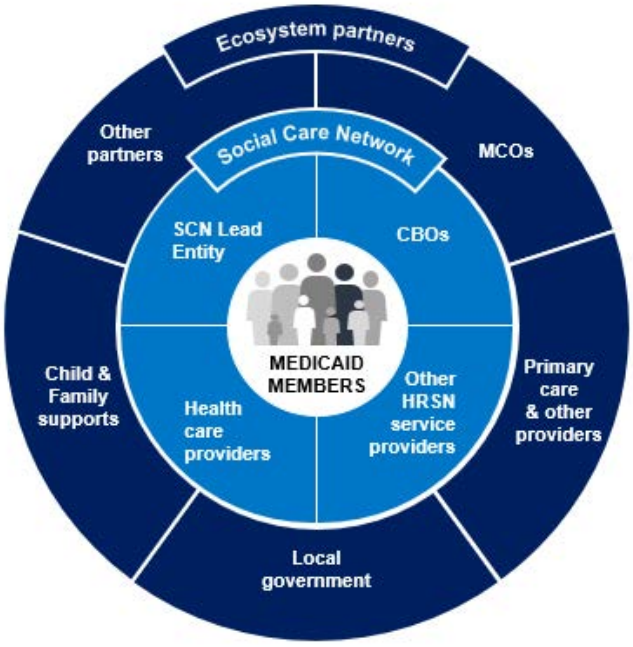
Overview

What is a Social Care Network (SCN)?

A Social Care Network (SCN) is a network comprised of HRSN service providers including community-based organizations, Medicaid managed care organizations (MCOs), health care providers, and other partners (see Figure 1). Network participants contract with and are coordinated and overseen by an SCN Lead Entity. Organizations that participate in an SCN, as well as SCN Lead Entities, can screen Medicaid Members for unmet HRSN needs and navigate them to HRSN services. HRSN service providers deliver services to Members, and SCN Lead Entities reimburse providers via funding from Medicaid Managed Care.

Figure 1. SCN and ecosystem partners



What is an SCN Lead Entity?

SCN Lead Entities are organizations with expertise in supporting New York Medicaid Members, a deep understanding of their region, and ability to coordinate an ecosystem of partners. They are responsible for creating and managing networks to provide screening and navigation to Medicaid Members, and ultimately to ensure services are delivered to address HRSNs (Figure 2).

Figure 2. Roles of SCN Lead Entities

- **Form partnerships** within the regional ecosystem to screen Medicaid Members for HRSN, navigate to services, and close the loop on referrals
- **Organize and contract a network** of health care and HRSN service providers, including CBOs, to screen, navigate, and deliver services
- **Pay HRSN service providers** for screening, navigation, and service delivered, as well as health care providers contracted to conduct screening and navigation.
- **Facilitate data-sharing** to support health care and HRSN service navigation and delivery.
- **Establish a leadership team** that reflects the unique needs of the region

Who are the SCN Lead Entities in New York State?

There are 9 SCN Lead Entities in 11 regions across the state, who have contracted with New York State Medicaid (Figure 3). These SCN Lead Entities have experience serving New York populations with culturally competent programing that meets the needs of the diverse populations they serve.

Figure 3. SCN Lead Entities by Region

	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

Services

What are enhanced HRSN services?

New York State Medicaid is expanding coverage of certain services that address HRSN, as evidence indicates that these benefits are critical drivers of an individual's access to health services that keep them well and may improve health outcomes. There are four categories of enhanced HRSN services reimbursable under New York's 1115 Waiver Demonstration: Nutrition, housing, transportation, and social care management (Figure 4).

Figure 4. Enhanced HRSN service categories and covered services

Service categories	Services
Nutrition	• Nutritional counseling and education • Medically tailored meals • Food prescriptions • Fresh produce and non-perishables groceries • Cooking supplies (pots, pans, etc.)
Housing	• Home accessibility and safety modifications • Home remediation (e.g., mold or pest remediation) • Asthma remediation • Medical respite (recuperative care) • Rent / temporary housing • Utility set-up / assistance • Housing navigation • Pre-tenancy services • Community transitional services (e.g., utility activation) • Tenancy sustaining services
Transportation	• Reimbursement for public and private transportation to connect to social care services (e.g., appointment with a housing navigator) • Note: excludes transportation to doctor's appointments
Social care management / navigation	• Outreach and referrals • Connection to employment, education, childcare, and interpersonal safety resources in addition to enhanced HRSN services listed above

Enhanced HRSN services are temporary and can range from short-term (e.g., 1-2 weeks) to longer-term (up to 6 months), depending on Member health and social needs. For example, some individuals may receive medically tailored meals for a short time post-hospitalization, while Members with high-risk pregnancies may receive nutrition interventions for up to the length of the pregnancy and up to two months postpartum.

How can Members be screened and access HRSN services?

Screening

Screening is a key step in identifying unmet HRSNs so that SCNs are able to connect Members to enhanced HRSN services and/or existing community, state, and/or federal supports. SCNs will use the Accountable Health Communities (AHC) Health-Related Social Needs Assessment tool for screening. Screening can be performed by employees of the SCN Lead Entity and/or by organizations in the SCN, including health care providers, via a shared data/IT platform or from the providers Electronic Health Record (or other interoperable system) to regional Qualified Entity (QE) that is connected to the Statewide Health Information Network for New York (SHIN-NY). Medicaid Members can be screened annually and as needed (e.g., upon a major life event).

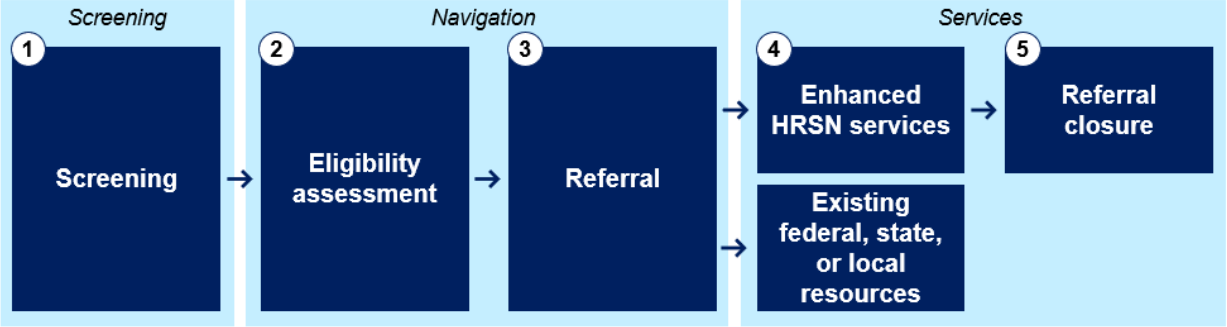
Screening may be reimbursable by the SCN if: the organization is contracted with the Lead Entity, screening is completed using the twelve questions from the AHC HRSN Screening tool, involves 1:1 interaction with a Medicaid Member, and is entered into the SCN's secure IT platform or sent through the QE/SHIN-NY) to the SCN.

Navigation

The role of Social Care Navigators is to connect Members to HRSN services. They may be employees of an SCN Lead Entity, health care providers, or HRSN service providers. Health care provider organizations may have their care managers, social workers, or community health workers play the Navigator role and help connect patients with HRSN services in their community. Social Care Navigators are essential to coordinating the process through which Medicaid Members are screened, connected with service providers in their community, and there is follow-up to ensure services were delivered and the Member's needs have been addressed (Figure 5).

Members can either be navigated to enhanced HRSN services or existing federal, state, or local resources depending on eligibility criteria (see Eligibility section below).

Figure 5. Member journey to access HRSN services



What organizations can provide enhanced HRSN services?

HRSN service providers are primarily CBOs but may include larger non-profits, health care, or in some cases private sector entities. Service providers should reflect the diversity and unique needs of each region. HRSN service providers may be but are not limited to:

- Community-based organizations (e.g., food banks and pantries, supportive housing organizations, voluntary foster care agencies) and regional non-profits
- Health care providers (e.g., hospitals with food prescription offerings in partnership with CBOs or directly)
- In some cases, for-profit service providers (e.g., private transportation companies, nurse-family partnerships, grocery stores) may also participate

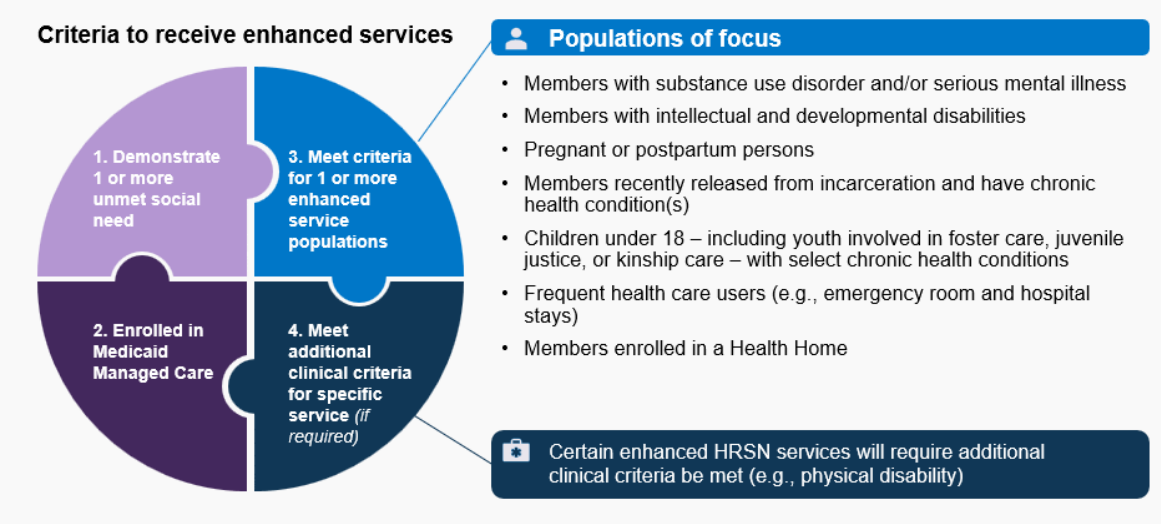
There is no minimum or maximum number of participating HRSN service providers in each regional SCN. If they are active in multiple regions, they may contract with multiple SCN Lead Entities.

Eligibility

Who qualifies for enhanced HRSN services?

Medicaid Members in both fee for service (FFS) and Medicaid Managed Care (MMC) can be screened for HRSN and receive navigation support to existing local, state, and federal supports. MMC beneficiaries may qualify for additional, enhanced HRSN services. To qualify for enhanced HRSN services, MMC Members must meet a set of criteria (Figure 6)

Figure 6. Medicaid Member eligibility requirements



What role do health care providers play in confirming Member eligibility?

Health care providers may support Members in accessing enhanced HRSN services by helping confirm eligibility when requested by Social Care Navigators. A Social Care Navigator may request Provider attestation in certain situations, such as when eligibility criteria are not available in the Member's MCO data. The attestation then allows the Member to be deemed eligible and receive enhanced HRSN services.

Providers may be asked to attest to presence of specific clinical criteria (e.g., diagnosis of chronic conditions including mental health diagnoses and substance use disorder, pregnancy or postpartum status, children's risk of malnutrition or history of low birth

weight, etc.). A completed Provider attestation form can be used for Members to be eligible for services such as but not limited to:

- Medically necessary home modifications (such as ramps, handrails, grab bars, etc.)
- Air conditioners, heaters, humidifiers, and dehumidifiers
- Refrigeration for prescribed medication for management of a chronic condition
- Asthma remediation
- Medical respite (recuperative care pre- or post-hospitalization)

The attestation process will consist of filling out a consistent form. Providers need not be contracted into the SCN to give a Provider attestation in support of the eligibility process. For more detail on attestation as well as other operational processes, contact your regional SCN.

Engaging with an SCN

How can health care providers engage with an SCN Lead Entity?

SCN Lead Entity role: SCN Lead Entities are responsible for building a network of organizations to deliver screening, navigation, and HRSN services within their region. Each SCN Lead Entity will contract with organizations and reimburse them for enhanced services delivered to qualifying Members, based on a regional fee schedule.

In addition, SCN Lead Entities support participating service providers with technical assistance and training, on topics such as:

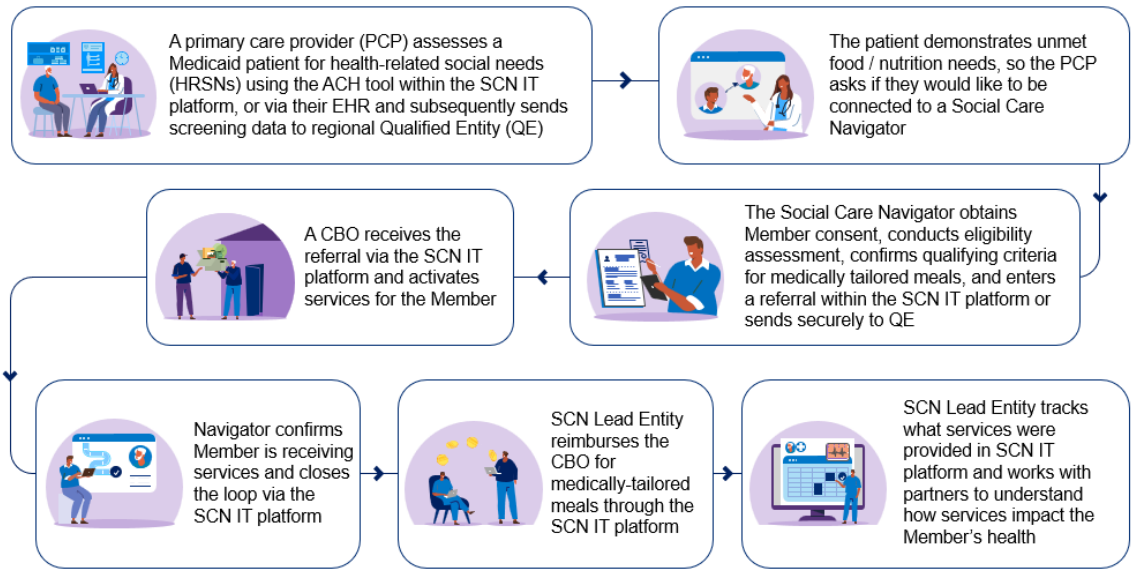
- Technology including a shared data / IT platform
- Cultural and linguistic competencies
- Trauma-informed approaches
- Considerations for special populations
- Workflows for delivery of certain HRSN services

Health care provider role: Health care providers can contract with SCNs (and be reimbursed) to screen Medicaid Members for HRSNs, navigate Members to HRSN service providers, and / or deliver enhanced HRSN services to Members (e.g., hospitals with on-site pantry and food prescription program). Health care providers joining a SCN are expected to use the SCN IT platform and comply with data requirements. They are encouraged to collaborate and share feedback with the Lead Entity to support ongoing improvement over the course of the demonstration period, to encourage program success and sustainability. SCNs are seeking to partner with health care providers that serve Medicaid Members as well as entities that coordinate care (e.g., Health Homes, Patient-Centered Medical Homes). SCNs seek to collaborate with a variety of providers, including hospitals, primary care practices, FQHCs, and behavioral health providers.

How will data and technology be used?

All service providers within each regional SCN will use a shared data / technology platform. SCN Lead Entities are responsible for selecting and onboarding participating organizations onto the data / IT platform and ensuring adherence to robust privacy and security requirements. Lead Entities are also responsible for partnering with a Qualified Entity (QE) to send HRSN data to the Statewide Health Information Network for New York (SHIN-NY) data lake. Data / IT platforms will have functionality for providers to conduct screening (upon consent), navigate Members to services, and provide closed loop referrals. Providers may also conduct screening via their electronic health record (EHR) and send screening data to their regional QE. Tech infrastructure is set up for the SCN program to enable data sharing between ecosystem partners in a secure way.

Figure 7. Examples of data-sharing across ecosystem partners within a SCN (not exhaustive)



Payment

What services are reimbursable?

SCN Lead Entities can reimburse service providers within their regional SCN for the provision of screening, navigation, and enhanced HRSN services to qualifying Members, based on a regional fee schedule.

How can health care providers be reimbursed?

To receive reimbursement, health care providers must:

- Contract with a regional SCN
- Do at least one of: screen Members for HRSNs using the AHC tool in the SCN IT Platform, provide social care navigation to help Members access to services, or provide enhanced HRSN service(s)
- Remain in Medicaid Good Standing by meeting state licensure requirements
- 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

Joining an SCN

How can you join a Social Care Network?

To learn more about becoming a health care provider in a SCN, reach out to the SCN Lead Entity in your service delivery region. If you provide services in more than one region, you may collaborate and/or contract with multiple SCNs if you provide services in more than one region. SCN Lead Entities will also be able to share more detailed operational guidance as you get started, including specific processes for your region and the services you provide to Medicaid Members in New York.