COMMUNITY HEALTH CARE ASSOCIATION of New York State

Last Updated: January 2025

# Social Care Network (SCN) Operations Manual Overview

## Introduction to the SCN Manual

The Social Care Networks (SCN) Operations Manual outlines the processes, requirements, and reimbursement mechanisms for addressing Health-Related Social Needs (HRSN) under New York's Medicaid waiver. This overview highlights key information for Health Centers but is not exhaustive. For complete details, refer to the full SCN Operations Manual.

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## Reimbursement Overview for Health Centers

Health Centers can contract with SCN Lead Entities and participate in multiple SCNs. Reimbursement is available for screenings, navigation, and enhanced HRSN services under the following conditions:

- **No Duplicate Payments:** Reimbursement for SCN services is only available for services that are not already reimbursed by Medicaid or other payers. Duplicate payments are not allowed.
- **Threshold Visits and SCN Activities:** Threshold visits reimbursed at the PPS rate are distinct from SCN services. Health Centers may provide both a threshold visit and SCN services (e.g., screenings or navigation) on the same day and receive separate reimbursement for each.
- **MCVR Reporting:** Revenue from SCN services should not be included in the Managed Care Visit and Revenue (MCVR) report, as these services are excluded from the Supplemental Payment Program.

## Reimbursement Breakdown

### Fee Schedule

SCNs use standardized fee schedules for screenings and care management:

| Service | Unit | Rate | Unit Max |
|---|---|---|---|
| Screening | Per 15 min | $17.50/unit | 2 units per year (add'l 2 units possible in major event); Max 4 units per year |
| Level 1 Navigation | Per 15 min | $17.50/unit | Up to 4 units allowed after each HRSN screening. Max 8 units per year. |
| Level 2 Care Management | Per 15 min | $17.50/unit | Max of 20 units per month |

Reimbursement for enhanced HRSN services varies across SCNs. Health Centers should review the specific fee schedules of the SCNs they participate in.

**Refer to:** Chapter 8, Section F: SCN Contract Requirements with HRSN Service Providers and Other Entities.

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**Screenings**

Screenings identify HRSNs of Medicaid patients, focusing on social determinants of health such as housing, food security, and transportation. Key requirements include:

- Use of the standardized AHC HRSN Screening Tool without modification.
- Direct, 1:1 interaction between the screener and the patient.
- Documentation in the SCN IT Platform.
- Annual screenings, with an additional screening permitted following a major life event.

Reimbursement for screenings is $17.50 per 15 minutes, up to 2 units.

**Refer to:** Chapter 5, Section 5: HRSN Screening and Eligibility Determination.

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**Care Navigation**

Care navigation ensures Medicaid patients receive support to address their HRSNs. It includes guiding patients through service connections, managing referrals, and creating Social Care Plans.

**Level 1: Navigation Services**

Navigation services, part of the existing Medicaid benefit, help patients connect to existing federal, state, and local resources.

- Reimbursement is $17.50 per 15 minutes
- For navigation services following an HRSN screening, reimbursement is limited to 4 units per screen.

**Level 2: Enhanced HRSN Care Management**

Enhanced HRSN Care Management provides intensive support for patients with significant, ongoing social needs. Key points:

- Includes sustained coordination for complex cases (Ex., housing instability, chronic transportation issues).
- Reimbursement is $17.50 per 15 minutes, with up to 20 units per month during the waiver period.

**Social Care Navigators**

Social Care Navigators play a critical role in delivering HRSN services. Their responsibilities include:

- Conducting screenings and eligibility assessments.
- Managing referrals and coordinating care.

- Creating and monitoring **Social Care Plans** (for more details, refer to **Chapter 7, Section H: Social Care Plans**).
- Following up to ensure patients' needs are met.

To qualify for reimbursement, services must involve **direct, 1:1 interaction** with the Member and align with the SCN's approved activities.

**Note:** NYS Medicaid envisions that Social Care Navigators will primarily be Community Health Workers (CHWs).

**Refer to:** Chapter 5, Section 5: HRSN Screening and Eligibility Determination, Chapter 6, Section 6: Care Navigation, Chapter 7, Section H: Social Care Plans.

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**Enhanced HRSN Services**

Enhanced HRSN Services address critical HRSNs and include:

| Care Management: | Housing Assistance |
|---|---|
| 1.1 Navigation Services | 2.1 Home Accessibility and Safety Modifications |
| 1.2 Enhanced HRSN Care Management | 2.2 Home Remediation Service |
| **Nutritional Support** | 2.3 Asthma Remediation |
| 3.1 Nutrition Counseling and Education | 2.4 Recuperative Care (Medical Respite) |
| 3.2a Medically Tailored Meals | 2.5 Rent / Temporary Housing |
| 3.2b Clinically Appropriate Home Delivered Meals | 2.6 Utility Setup / Assistance |
| 3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions | 2.7 Pre-tenancy Services |
| 3.4 Fresh Produce and Non-perishable Groceries (Pantry Stocking) | 2.8 Community Transitional Supports (CTS) |
| 3.5 Cooking Supplies | 2.9 Tenancy Sustaining Services |
| **Transportation Services** | 2.10 Housing Transition and Navigation Services |
| 4.1 Transportation Services | |

**Eligibility for Enhanced HRSN Services**

To qualify, a patient must meet these criteria:

1. **Unmet HRSN Social Risk Factor:** A documented need (Ex., lack of food, housing, or transportation).
2. **Enhanced Population:** Membership in a priority group (Ex., individuals experiencing homelessness or Medicaid High Users). *See Table 5-4 below for the full list of eligible populations.*
3. **Clinical Criteria:** A medical or behavioral health condition worsened by the unmet social need.

4. **No Duplicate Services:** The patient must not already be receiving equivalent services from other programs.

**Example:** An individual experiencing homelessness (*enhanced population*) with a chronic respiratory condition (*clinical criteria*) and unstable housing *(social risk factor*) qualifies for housing transition services.

Reimbursement for Enhanced HRSN Services is determined by each SCN's fee schedule.

**Refer to:** Chapter 5, Section 5: HRSN Screening and Eligibility Determination, and Table 5-16: Enhanced HRSN Services

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**Documentation and Attestation for Eligibility**
The SCN may require documentation and attestation to demonstrate a patient's social risk factors, eligibility for enhanced population services, and clinical criteria.

**Provider Attestation**
Providers may need to complete a standardized attestation form confirming that the patient meets enhanced population and clinical criteria. This may include situations where the patient was screened or navigated by another organization within the SCN, but requires provider to complete the attestation. Filling out this form is not separately reimbursable.

See the Provider Attestation Here: Provider Attestation Form and Instructions.
*This attestation form and instructions are subject to change. Please ensure you are using the most recent version.

**Additional Documentation Methods**
Eligibility can also be documented through:

- **Eligibility Screening and Management Form (ESMF):** Used to document unmet HRSNs.
- **Member Attestation:** A written or verbal statement from the patient detailing their social circumstances.
- **Member Documentation:** Supporting evidence provided by the patient (e.g., eviction notices or medical records).

**Responsibility for Collecting Documentation**
Social Care Navigators are responsible for assisting patients in obtaining and submitting required documentation. This includes:

- Explaining acceptable forms of documentation and submission methods.
- Supporting patients in completing and submitting attestation or documentation forms.
- Storing all documentation securely in the SCN IT platform.

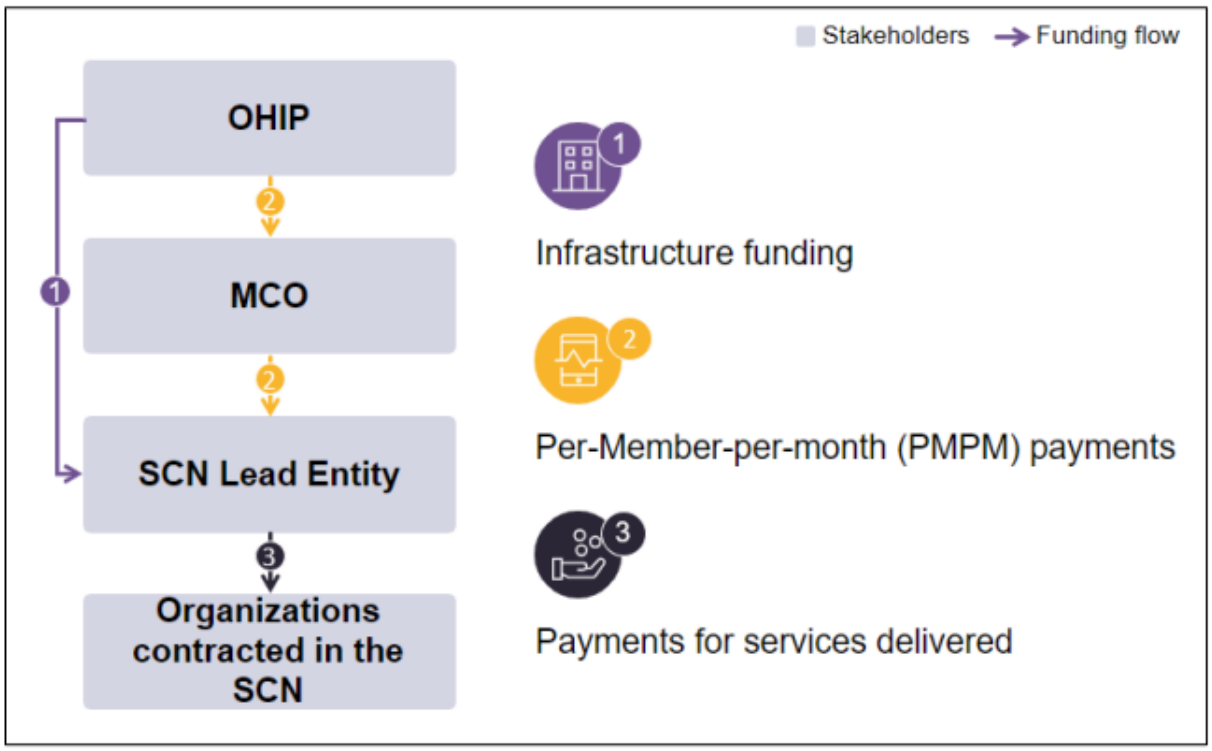
**Refer to:** Chapter 5, Section 5: HRSN Screening and Eligibility Determination, and Table 5-151: Documentation Requirements.

**Payments Overview**

The funds flow for the SCN program is structured as follows:

1. **OHIP (NYS Medicaid)** pays Managed Care Organizations (MCOs) a per-member-per-month (PMPM) rate to cover the costs of HRSN services.
2. **MCOs** then pay SCN Lead Entities a PMPM rate to coordinate and deliver HRSN services within their networks.
3. **Health Centers** are reimbursed on a fee-for-service (FFS) basis for SCN activities, such as screenings, navigation, and enhanced HRSN services, based on the standardized fee schedule.

**Figure 7-1: Overview of payment flows included in SCN program**




**Use of Infrastructure Funding**

SCNs can use Infrastructure funding for Health Centers to:

- Support entities contracted into the SCN to onboard onto the SCN IT Platform (Ex., vendor or user licenses).
- Build technical capabilities of entities contracted into the Network (Ex., additional training not provided by IT vendors).

**Note:** Capacity-building funding for CBOs may not be used for Health Centers.

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Last Updated: January 2025

**FAQs**

1. **Can SCN services be billed on the same day as a threshold visit?**
   Yes, SCN services (Ex., screenings, navigation, HRSN services) provided on the same day as a threshold visit can be reimbursed separately from the PPS rate.

2. **Should SCN service payments be reported on the MCVR?**
   No, revenue from SCN services is excluded from MCVR reporting.

3. **Can a Health Center participate in multiple SCNs?**
   Yes, Health Centers are encouraged to join SCNs covering the regions where their patients live. Patients are attributed to SCNs based on their last known address, not the location of the clinic where they receive care. Therefore, Health Centers should contract with SCNs in the regions where their patients reside to ensure seamless coordination and reimbursement for services.

4. **What screening tool needs to be used?**
   The AHC HRSN Screening Tool must be used. Question 0 of the tool must also be included and documented in the SCN IT platform.

5. **Do HRSN service rates vary across SCNs?**
   Yes. While screenings and care navigation are reimbursed at a standardized rate of $17.50 per 15 minutes across all SCNs, rates for other HRSN services may vary. Health Centers must review the specific fee schedules of the SCNs they participate in to determine reimbursement rates for additional HRSN services.

6. **What is the difference between care navigation and enhanced care management?**

   - **Level 1 Care navigation** refers to pre-waiver activities that help connect patients to general social services, manage referrals, and follow up on service delivery. It is limited to 8 units per year, with 4 units allowed following an HRSN screening.

   - **Level 2 Enhanced care management** is a new service under the waiver that focuses specifically on connecting patients to HRSN services and providing intensive coordination for those with significant ongoing needs (Ex., housing instability or chronic transportation issues). Enhanced care navigation allows up to 20 units per month during the waiver period.

7. **Once a patient begins receiving Enhanced HRSN Services, are they eligible to continue receiving these services through the end of the waiver?**

   No, Enhanced HRSN Services are not provided on an ongoing basis. While these services are available under the waiver until it concludes, individual service periods are generally limited to 6 months, unless an extension is clinically justified. Social Care Navigators are responsible for notifying patients when their Enhanced HRSN Services are approaching the end of the approved period and facilitating their transition to existing community or Medicaid services. For detailed guidance on notification and transition procedures, refer to Chapter 5, Section 5: HRSN Screening and Eligibility Determination in the SCN Operations Manual.

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# Reference Page: Key Charts from the SCN Operations Manual

## 1. Eligible Populations for Enhanced HRSN Services

**Table 5-4: Populations eligible for Navigation and Enhanced HRSN Services**

*For latest eligibility criteria, refer to:*
https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/index.htm

| | |
|---|---|
| **Navigation services** | **Medicaid FFS Members** and enrolled **Medicaid Managed Care Members** who do not meet Enhanced Population criteria for Enhanced HRSN Services below. Members will receive navigation to existing federal, state, and local services to address HRSNs. |
| **Enhanced HRSN Services** | **Enrolled Medicaid Managed Care Members**, who meet one or more of the following criteria and have an identified unmet HRSN.<br>Enhanced HRSN Services criteria (additional details follow in HRSN Services Section):<br>i. *Medicaid High Utilizer* (defined by Emergency Department or inpatient utilization)<br>ii. *Individuals enrolled in a NYS-designated Health Home*, which currently includes individuals with HIV/AIDs, Serious Mental Illness, Serious Emotional Disturbance, Complex Trauma, or two or more chronic conditions (such as, diabetes, congestive heart failure (CHF), chronic kidney disease, chronic obstructive pulmonary disease (COPD), pre-diabetes, obesity, hypertension, malignancies (cancer), asthma, sickle cell, or HIV/AIDS)<br>iii. *Individuals with Substance Use Disorder (SUD)*<br>iv. *Individuals with Serious Mental Illness (SMI)*<br>v. *Individuals with an Intellectual and Developmental Disability (I/DD)*<br>vi. *Pregnant and postpartum persons*<br>vii. *Individuals who are up to 90 days post-release from incarceration with a chronic condition*, including SUD and chronic Hepatitis-c<br>viii. *High-risk children under the age of 18 (including justice-involved youth, foster care youth, and those under kinship care)* |

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**Figure 5-1: Member journey from screening to Social Care Navigation, service provision, and Referral closure**