HEALI Meeting
July 17, 2024

HEALI Social Care Network Updates:

- HEALI Team convened health system partners to discuss the screening capacity. Discussing ways to optimize current screenings and think through consents.

CBO Requirements

- Provides screening, navigation or one of the enhanced HRSN services
- Cover zip codes in Nassau and Suffolk Counties
- Non-profit with EIN (501c3)
- Designates contact(s) to engage and be trained on Unite Us
- Committed to accepting referrals, providing services and collaborating with the SCN and other stakeholders to coordinate HRSN service delivery

CBO Capacity Building

- CBO Readiness Assessment including technology, staff, training; Will inform capacity building plans
- HEALI will contract with CBOs to complete plans and provide payments based on achieved metrics
- Training and support with emphasis on understanding the needs of our communities and Medicaid members to ensure culturally competent and responsive care:
    - Onboarding to Unite Us
    - Training on screening, referral and navigation
    - Special population training
    - Enhanced services training

CBO Assessment and Onboarding

- An early step in onboarding CBOs to the SCN will be to conduct a Readiness Assessment
- The Readiness Assessment will likely be a survey-style self assessment hosted on the web, may include a follow-up interview
- Intent is for the Assessment to help HEALI understand where capacity can be built and identify CBO needs for resources and support via the Capacity Building Program
- Key areas of the assessment will include:
    - Collection of basic demographic information about the organization
    - SCN Service Capacity to conduct Screenings and Enhanced Services
    - Assessment of current CBO experience and comfort in areas such as trauma informed care, health equity, and linguistic accessibility
    - Technology, data, security, and broad IT capacity and capability
- First iteration of the assessment will likely launch in the Fall
    - Key input into the development of the Assessment will be guidance from the State (in the form of the Program Manual)
    - CBO Training and Capacity Building Advisory Committee review and input
- Following the Readiness Assessment immediate next steps will include:
    - Enrolling the CBO in relevant capacity building programs based on needs
    - Onboarding to Unite Us (if not already completed)
    - Enrolling the CBO in relevant trainings
    - Executing contracts and data sharing agreements with the SCN

Emily Engel, Director of Bureau of Social Care and Community Supports, New York State Department of Health

1115 Waiver Updates

- Award announcement is expected in the coming weeks
- Operations Manual will include details for the SCN, including covered services, screening, navigation, payment, etc.
    - Expected to be done around August 1
- State is completing the templated agreement between Managed Care Organizations and SCNs, template agreement for SCN and CBOs
    - Working to standardize language and terminology because it is a short time frame to start providing services
- NYS submitted a protocol to CMS for approval and CMS gave back positive feedback on the approval
    - Services will pay for screening and navigation of Medicaid members
    - Enhanced services are:
        - housing supports: navigation to find housing, community transitional services – furniture, security deposit, broker's fee, 6 months of rent and utilities, arrears, pre-tenancy and tenancy sustaining services, home remediation, home accessibility and safety modifications, medical respite for homeless population
        - nutrition: counseling and classes, medically tailored meals, food and vegetable prescription, pantry stocking
        - transportation for services that are not being delivered, transportation for case management, housing interviews
        - case management: connecting individual to other resources like SNAP and WIC, paying for DMV fees, connection to clinical case management, education, employment, childcare, interpersonal safety resources, follow-up
    - rescreening of members if there is a life change
- Data and IT infrastructure:
    - State will be able to see what the needs are at a community level and see the journey of the members and the impact of the SCN

NYS Social Care Network Landing Page: http://www.health.ny.gov/mrt/sdh

Discussion:
Question: Will there be guidance on how often or when rescreening has to occur?
Answer: There will be a guidance section on rescreening. There will be an annual screening paid through the waiver. If someone experiences a life event that we define broadly (ex: losing a job, death of family member, moving/eviction), they can be rescreened and that will be paid for.

Question: Can you please speak about the State's work with the QEs and the SHIN-NY pertaining to data sharing between MCOs and SCNs?
Answer: The state is working on a standardized roster for each MCO that includes their whole membership, and the enhanced services population will be identified through the roster. The roster will be sent through the QE and SHIN-NY to the SCN to pull into their IT platform. When a navigator screens an individual, they will be able to see the eligibility in the platform. In some cases, such as when a navigator might know someone is eligible before the health plan (ex: pregnant person), the SCN would still provide the service and the SCN would let the MCO know about the change. The first QE SHIN-NY

data point is the roster and the second is the data from the screening. Services will all go through the QE to the SHIN-NY so that providers will be able to see the screening results. If there is a provider who screens outside of the Network, the screening can go to the data lake and the SCN can pull that data down. We'll be using HCSPCS codes to track the actual services and that will go through claims to the MCOs and up to the DOH. There is a spreadsheet the team has been working on that has the screening questions with the codes and the mapping of the data.

Question: Will there be one QE that the State expects the MCOs to work with, or the regional QE?
Answer: The regional QE. NYeC has been working with the QEs to get ready for the social care data.

Question: Can you share any additional details about what the patient consent requirements will be like, where it will happen, how it should be documented?
Answer: There will be a universal consent that everyone uses and that is part of the SHIN-NY. So, there will only be one consent that is used and that will check for getting the services, screening, sharing the screening and service information. There will be a lot more information in the manual about how that is implemented but it is all electronic consent.

Question: Regarding individuals enrolled in health home care coordination, will they be eligible for the screening and services?
Answer: Health home is one of the enhanced populations, so they are eligible for the waiver services. Those individuals do get screened through the health home and then can get navigated to the SCN and to services depending on the health home/SCN contracting relationship.

Question: There is concern for those who are deaf and especially senior citizens that this community hasn't been included to see if the screening questions will be viable. The questions should be in plain language and ASL should be incorporated and translatable.
Answer: We have a standardized tool we're using, the AHC HRSN Screening, which will be required to participate in the waiver. It's done in multiple languages and can be done in ASL.

Question: For the organizations that will be doing the initial screenings, will that roster be available to them or is it expected they go out in the community to screen?
Answer: In a perfect world, that roster will be incorporated into the IT platform so that when you're screening a member, you know they're eligible for the services. This is the most member-friendly approach to do it so they're not waiting for confirmation on eligibility. All members are eligible for screening and navigation. The idea is to have the enhanced population flagged so it is seamless for the member.

Question: The MCOs are going to get the full roster of everyone in the two counties, then those rosters are going to be disseminated to the SCN for dissemination to the CBOs?
Answer: The roster will be incorporated into the IT Platform. So a navigator can look up the client they are screening and will know if they are eligible for enhanced services. It won't be a data dump to the CBOs.

Question: Is the state going to take an analysis of the attributed lives to primary care providers that also has a pivot on the social care needs of that population as well so there is not duplication? How will that interface be contemplated? MCOs attribute lives to primary care providers because they do it based on NPI number.

Answer: It's going to go by the primary residence for where they get attributed to. The state chose the address because we felt for social means, it's really important to get the community-based organizations that are down the block from them, and we didn't want people to be assigned to a SCN that isn't within their home.
Question: Will the CBOs have available information as to who the resident's primary care provider is at the time of service?
Answer: I don't think that is on the roster. They might have access to it through E paces but would have to double check.

Question: What are the guidelines and restrictions about for-profit and non-profit organizations requirements for participation in the SCN?
Answer: Preference in the waiver is given to non-profit organizations and capacity building dollars are for non-profit organizations. But say there is a gap and the SCN says they need to use this for-profit entity because there is not enough capacity yet for non-profit service providers. The state is leaving that up to the SCN and there will be a process for the SCN to determine. There will be guidance in the operations manual.

Question: We were going through the screening questions and comparing them with the enhanced services and the questions wouldn't necessarily tell the navigator which service is most appropriate.
Answer: The standard questions are broader and then there are assessment questions after screening positively for an unmet need. We will have guidelines for the follow-up questions and we will leave some flexibility there. This is where you have conversations with the Medicaid member.

Question: There are questions around interpersonal safety, is there an obligation for the navigator to create a safety plan?
Answer: We don't anticipate the navigator making the safety plan. The navigator will connect the individual with the appropriate service provider. The navigator refers the individual to eligible services. There will be guidance around that question because those questions are very sensitive. We don't want people asking if the partner is in the room, because there is an appropriate time and place. There will be guidance about when those questions should be asked, training around those questions, being trauma-informed. If the screening doesn't have those questions filled out, it's not an incomplete screening. It's the navigator's decision that that wasn't an appropriate question to ask at that time, and so giving flexibility on those questions because of their sensitivity.

Question: How will the intellectual and development disability (IDD) population be identified?
Answer: On the roster, we are creating a data pull for the Managed Care organizations and they will be able to identify the enhanced population through the data pull, which includes IDD population.

Question: In reference to the data pull from the MCOs, have they scrubbed those lists? How recent are they to ensure that they are up to date?
Answer: The data pulls will be monthly submissions. They will be updated on a regular basis and if there is a member not on that the SCN identifies, the SCN can change that.

Question: How as a CBO are we notified to look up that individual person?
Answer: The SCN will say who is a navigator and that navigator can screen an individual in the IT platform. There will be a data process flow for finding out if an individual has Medicaid. If you're a navigator, you're going into Unite Us and doing the screening and referral. If you're a CBO and get a referral, you're going into the IT platform and seeing the referral.

Question: Is there a timeline for the manual?
Answer: We're hooping around 8/1 because that will be when the contracts are executed. The manual will go out in a few phases, but the essential information will be phase one.

Question: Will there be guidance to help us reduce duplication of efforts?
Answer: Yes. We will have guidance on other care management agencies and their interactions with SCNs. As part of the roster, if there are duplicated services the member is receiving (ex: nursing home transition diversion waiver, might be getting meals or housing), we'll have those flags on there and there will be assessment questions if they are receiving services through X program.

Question: Is there an update on the HERO?
Answer: I do not have an update on the HERO. The SCNs will be announced before the HERO. There is an opportunity to come back and bring more information on the HERO.