

Transforming Home Care:  
Leveraging the Medicaid 1115 Waiver



Welcome

**SHERLY DEMOSTHENES-ATKINSON**

MHA, CEO, CABS Health Network

**KEVIN HOWELL,**

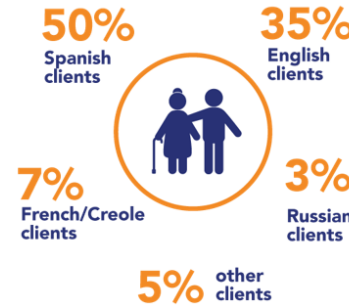
MBA, CEO Anchor Group & CABS Chief Strategic Consultant

# PRESENTATION OBJECTIVES

- Understand the key components of New York State's 1115 waiver and its approach to addressing social determinants of health.
- Learn about the roles and responsibilities of Social Care Network (SCN) Leads in coordinating care and community resources.
- Explore practical strategies for home care agencies to collaborate with SCN Leads to improve patient outcomes.
- Gain insights into integrating social care with healthcare services for a more holistic approach to patient care.

# CABS BACKGROUND

Community-based licensed home care and care management agency providing health and social services resources, and committed to integrated care, anchored in the slogan, **“where innovative healing, teaching, and discovery come together.”**



## Home Care Services

- Personal Care Services
- Home Health Aide
- Housekeeping

## Care Management

- Care Coordination
- Transition Services
- Medical Social Worker
- Integrated Pest Management Services for Asthma Patients
- Community Health Workers
- Health Homes

## Clinical Services through Partnerships

- Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Restorative Nursing Partnerships – e.g., Wound Care Management

# TRANSFORMING HOME CARE AGENCY MINDSET

**The New Normal** – Adopting a value-based care approach is not just a nice thing to have; *it is a sustainable business model.*

**Integrative Care** – Tailored and consistent quality in care delivery is the responsibility of all personnel involved in the continuum of care and requires a 360-degree view of care.



**Regulation & Culture Shift** – Making a shift to the pay-for-value over volume model requires an understanding of changes in regulation and a shift in the behavior of an organization.

**Translate the Model in the Daily Operation** – CABS has operationalized the VBP model at a functional level to improve care outcomes.

# SNAPSHOT OF THE MEDICAID 1115 WAIVER

The **Medicaid 1115 waiver** is a provision under Section 1115 of the **Social Security Act** that allows states to implement innovative approaches to their Medicaid programs.

- Allows states flexibility to test new ideas for delivering and financing Medicaid services, allowing them to operate outside some federal Medicaid requirements.
- The main goals of the waiver:
  - Improve health outcomes and **patient satisfaction**
  - **Reduce unnecessary hospitalization and disease exacerbation**
  - Lower healthcare costs
  - Address Social Determinants of Health (SDOH), and specific needs of the state's Medicaid population
  - Implement valued-based models, where providers are rewarded for outcomes, rather than volume

# SNAPSHOT OF NEW YORK STATE MEDICAID 1115 WAIVER

The **New York State 1115 waiver** focuses on initiatives like the Social Care Network to address the **social determinants of health** (SDOH), such as:

- Housing
- Food insecurity
- Transportation
- Employment

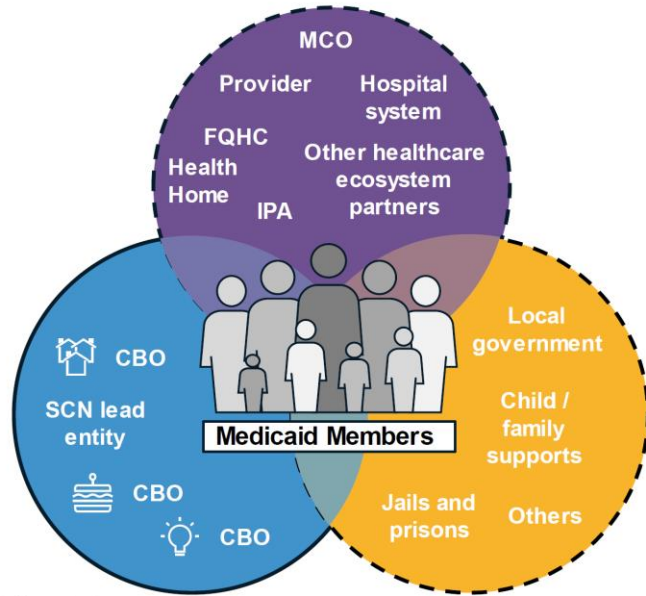
The waiver aims to promote comprehensive care by integrating **healthcare services with social services**.

Jan 9, 2024, CMS approved New York’s request for New York Health Equity Reform (NYHER) 1115 Waiver Amendment through March 31, 2027.

Initiative	Total	Percent of Total
<b>Health Related Social Needs Services</b>	<b>\$3.9B</b>	<b>51.9%</b>
<i>HRSN Direct Services</i>	\$3.4B	45.2%
<i>HRSN Infrastructure</i>	\$500M	6.7%
<b>Medicaid Hospital Global Budget</b>	<b>\$2.2B</b>	<b>29.3%</b>
<b>Workforce</b>	<b>\$690M</b>	<b>9.2%</b>
<i>Student Loan Repayment</i>	\$48M	0.6%
<i>Career Pathways Training</i>	\$646M	8.6%
<b>HERO Funding</b>	<b>\$125M</b>	<b>1.6%</b>
<b>Primary Care Investment</b>	<b>\$492M</b>	<b>6.5%</b>
<b>Continuous Eligibility for Children Ages 0-6</b>	<b>\$112M</b>	<b>1.5%</b>

# SOCIAL CARE NETWORK

Addressing health-related social needs requires a multi-faceted and holistic approach, relying on collaboration, innovation, and a deep understanding of community dynamics.



1. Where entities above are not part of SCNs

- Social care network (SCN)
- Healthcare ecosystem partners<sup>1</sup>
- Other ecosystem partners<sup>1</sup>

## Impact of future state system on Medicaid members

-  Scaled delivery of social care services and improved access for Medicaid members
-  Reliable and timely referral of members to social care services
-  Seamless tracking of members needs to streamline and close loop on referrals to social care services
-  Improved and increased collaboration between social care service providers and other partners in regional ecosystem (e.g., healthcare providers, care management providers, MCOs, others)

Person-Centered, Evidenced-Based, & Culturally Sensitive Services to Drive Equity

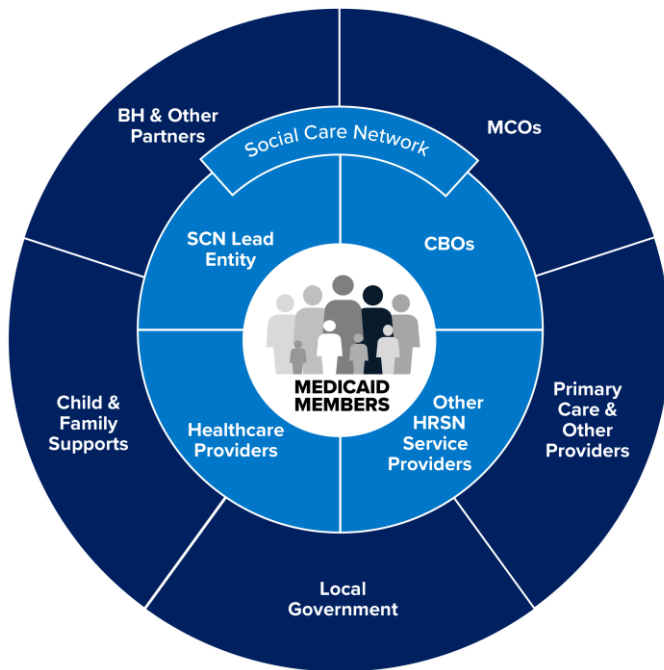
Seamless Access to HRSN & Clinical Support through Collaborations & Partnerships

Integrated Best-of-Breed Technology to Facilitate Connections

Community Empowerment for Scaling of Advocacy & Impact

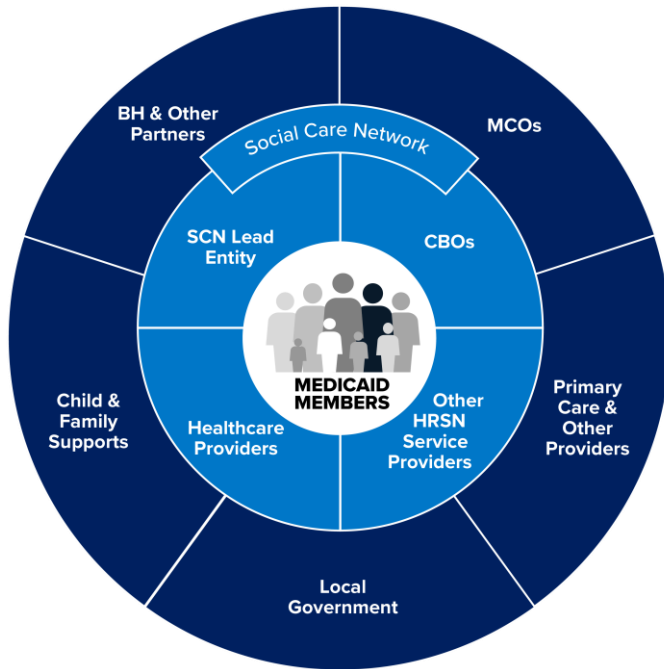
Research Data for Predictive Analysis

# SOCIAL CARE NETWORK SERVICES



- **Value-Based Payment (VBP):** Shift from fee-for-service to a value-based model.
- **Care Coordination and Integration:** Focus on integrating care across settings, including home care, hospitals, clinics, and community organizations.
- **Addressing Social Determinants of Health (SDOH)**
- **Population Health Management:** Prioritize high-risk populations, focusing on preventative and proactive care.
- **Enhanced Data and Reporting Requirements:** Improve data collection, analytics, and reporting for better monitoring of patient outcomes.

# SOCIAL CARE NETWORK SERVICES



What will the member experience?

**Screening**

Member is comprehensively screened for HRSN using **standardized screening tool that assesses their unmet needs** whether they would like to receive social care services, and collects their basic contact information

Which entities in the SCN will do this?

- SCN lead entity ✓
- CBOs conducting screening ✓
- Other CBOs in SCN <sup>1</sup> ✗

Which entities outside of the SCN can do this?

- Healthcare providers
- Care management providers
- MCOs

**Social care service navigation**

If the entity that conducted screening is part of the SCN OR has access to the Data and IT platform, they **immediately validate the member's eligibility** for Enhanced services using information provided by the member's MCO and results of HRSN screening and **navigate them to the appropriate social care services**

If not, member will be informed that **they will be rapidly contacted by the SCN** to receive navigation to services

Which entities in the SCN will do this?

- SCN lead entity ✓
- CBOs conducting screening ✓
- Other CBOs in SCN ✗

Which entities outside of the SCN can do this?

- Healthcare providers<sup>2</sup>
- Care management providers<sup>2</sup>
- MCOs<sup>2</sup>

**Services**

Member is able to **select among a network of CBOs from which to receive needed services** and continues to receive services until need is addressed

At any point, member is **able to engage with SCN social care service navigators** to discuss their evolving needs

Which entities in the SCN will do this?

- SCN lead entity ✓
- CBOs conducting screening ✓
- Other CBOs in SCN ✓

Which entities outside of the SCN can do this?

- CBOs providing services outside of the waiver (navigation to existing services only)

**SCNs will be required to develop a process that is timely and seamless for members**

1. Other CBOs in SCN may screen members but cannot be reimbursed without using standardized screening tool 2. If able to access the SCN Data and IT platform

# TARGETED POPULATIONS

Navigation	If a member does not meet the criteria for Enhanced HRSN services, they will receive navigation to pre-existing state, federal, and local programs to address HRSN.
Enhanced Services	<p>If a member is enrolled in Medicaid Managed Care, screens positive for an unmet HRSN and meets one of the following criteria:</p> <ul style="list-style-type: none"> <li>• <b>Medicaid High Utilizer</b> (defined by Emergency Department, Inpatient, or Medicaid spend or transitioning from an institutional setting)</li> <li>• Individuals enrolled in a designated <a href="#">Health Home</a> which currently includes HIV/AIDS, Serious Mental Illness, Sickle Cell Disease, Serious Emotional Disturbance or Complex Trauma (children only), or those with two or more chronic conditions (e.g., diabetes and chronic obstructive pulmonary disease)</li> <li>• <b>Pregnant Persons / up to 12 months Postpartum</b></li> <li>• <b>Post-Release Criminal Justice-Involved Population</b> with serious chronic conditions, SUD, or chronic Hepatitis-C</li> <li>• <b>Juvenile justice involved, foster care youth, and those under kinship care</b></li> <li>• <b>Children under the age of 6</b></li> <li>• <b>Children under the age of 18 with one or more chronic condition</b></li> <li>• <b>Substance Use Disorder</b></li> <li>• <b>Intellectual or Developmental Disability (I/DD)</b></li> <li>• <b>Serious Mental Illness</b></li> </ul>

# LEAD SOCIAL CARE NETWORK ENTITIES

Region	Lead Entity	Contact Person	Capacity Funding Available
<b>Southern Tier</b>	Care Compass Collaborative	Executive Director Mark Ropiecki	\$22.6 M
<b>Finger Lakes</b>	Finger Lakes IPA Inc.	Executive Director Patty McMahon	\$38.6 M
<b>Long Island</b>	Health and Welfare Council of Long Island	Executive Vice President Lori Andrade	\$42.2 M
<b>Capital Region, Central NY, North Country</b>	Healthy Alliance Foundation Inc.	CEO Erica Coletti	\$85.4 M
<b>Hudson Valley</b>	Hudson Valley Care Coalition, Inc.	CEO Amie Parikh	\$44.9 M
<b>Manhattan, Queens, Brooklyn</b>	Public Health Solutions	Executive VP & Chief Strategy Officer Zachariah Hennessey	\$152.4 M
<b>Staten Island</b>	Staten Island Performing Provider System	Executive Director Dr. Joseph Conte	\$22.5 M
<b>Bronx</b>	Somos Healthcare Providers, Inc.	Chief Operating Officer Lidia Virgil	\$54.5 M
<b>Western NY</b>	Western New York Integrated Care Collaborative Inc.	Executive Director Nikki Kmicinski	\$36.9 M

# MAPS OF REGIONS

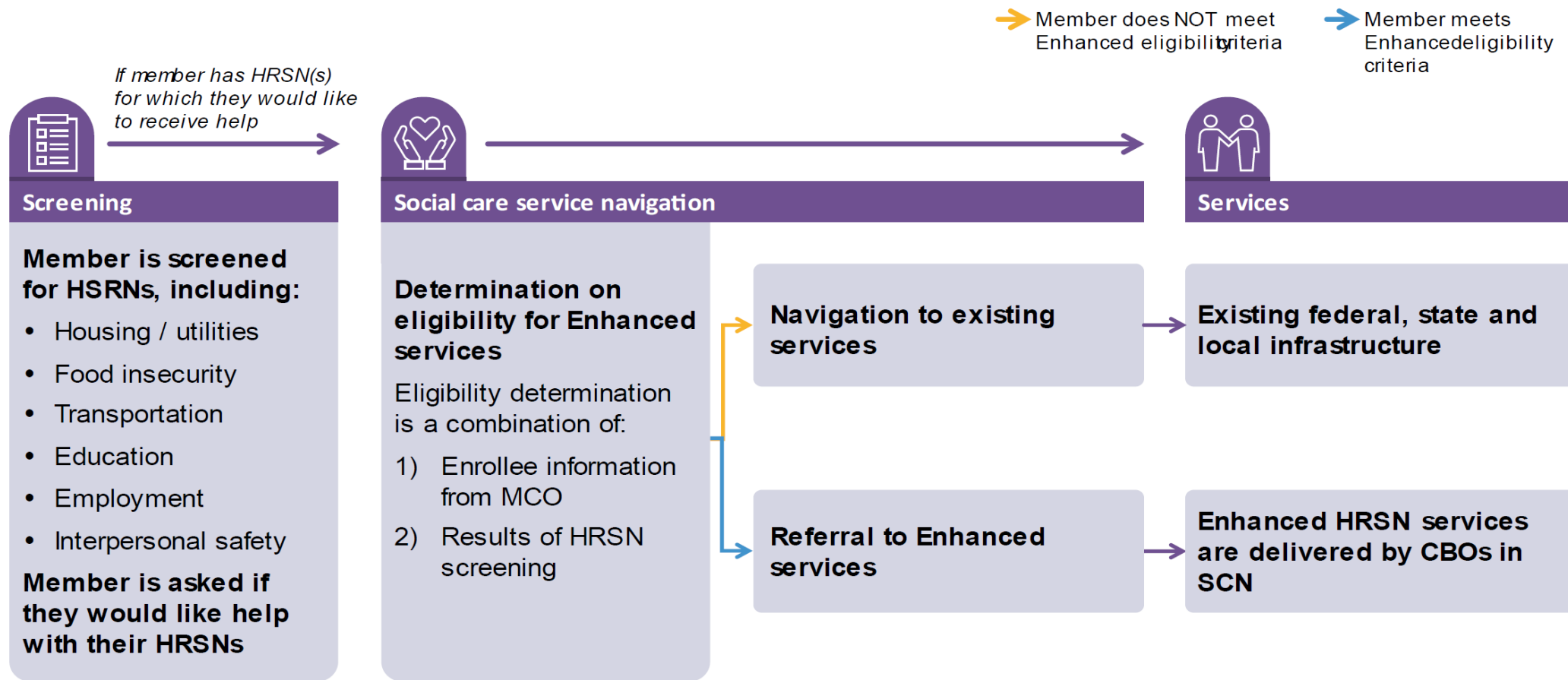


Map Color	Counties
●	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
●	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
●	Nassau, Suffolk
1	Albany, Columbia, Greene, Rensselaer, Montgomery, Saratoga, Schenectady, Schoharie
2	Cortland, Herkimer, Madison, Oneida, Onondaga, Oswego
3	Clinton, Essex, Franklin, Fulton, Hamilton, Jefferson, Lewis, St. Lawrence, Warren, Washington
●	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
●	Manhattan, Queens, Brooklyn
●	Richmond
●	Bronx
●	Cattaraugus, Chautauqua, Erie, Niagara

# ROLES & RESPONSIBILITIES OF THE LEAD ENTITIES

- Set up a governance board to guide the operations of the SCN
- Build operation capacity to support the SCN services
- CBO and partners/alliance network management
  - Execute needs assessments to evaluate CBO infrastructure and capacity gaps
  - Grant & funding management
  - Payment management for services
  - Training & capacity building
- Manage data & IT, human capital, finance and accounting infrastructure
- Manage Performance

# FLOW OF SERVICES FOR MEMBERS



# OVERVIEW OF SCREENING SERVICES

NYS recognizes the growing body of evidence that demonstrates how the identification of HRSN, such as housing, food/nutrition, interpersonal safety, and referrals to services can have a positive impact on member health outcomes.

- CBOs that **are non-profits with a registered Federal EIN.**
- CBOs must be part of a SCN.
- Medicaid members will be screened at least annually using the New York State-standardized version of the **Accountable Health Communities (AHC).**
- HRSN screenings will be conducted in multiple modalities, at accessible times, in culturally and linguistically competent ways.
- Lead entities will be accountable for tracking the results of HRSN screenings through their data and IT platforms.
- Focused on providing tailored services for each Medicaid members.
- Payment for screening - **\$17.50 per unit of service (15 minutes).**

# OVERVIEW OF NAVIGATION SERVICES

- Results of a Medicaid member’s HRSN screening will serve as a key input that informs how members are navigated to the appropriate social care services.
- Eligibility criteria are still being defined by the NYS in collaboration with MCOs and SCN lead entities.
- Eligible Medicaid members will be navigated to social care services covered by the waiver and delivered by CBOs in the SCN.
- Non-eligible Medicaid members will be directed to existing federal, state, or local social care infrastructures.
- SCNs will access this eligibility information directly through the SCN’s data and IT platform and navigate a member to services accordingly.

<b>1. Care Management</b>	1.1 Navigation Services	Per 15-minutes	Max of 8 units per year. Navigation services following each HRSN screen have max of 4 units	\$17.50
	1.2 Enhanced HRSN Care Management	Per 15-minutes	20 units per month for Waiver period	\$17.50

# SERVICE OPTIONS & FEES

Service Types	Service Name	Unit of Service	Max Units / Duration	SCN Lead Entity Rate /
<b>Screening</b>	Screening	Per 15-minutes	Max of 4 units per year to account for annual screen (max 2 units) and rescreen with major life event (max 2 units)	\$17.50
	<hr/>			
<b>Care Navigation</b>	1.1 Navigation Services	Per 15-minutes	Max of 8 units per year. Navigation services following each HRSN screen have max of 4	
	1.2 Enhanced HRSN Care Management	Per 15-minutes	20 units per month for waiver period	\$17.50
<hr/>				
<b>Housing</b>	2.1 Home Accessibility and Safety Modifications			
	2.2a Home Remediation Service: Mold and Pest Remediation	Cost-based, up to cap	Up to capped amount for Waiver period	\$10,000.00
	2.2b Home Remediation Service: Ventilation Improving Systems			
	2.2c Home Remediation: Equipment Provision			
	2.3a Asthma Remediation: SelfManagement Education	Per 15-minutes	16 units (In-person); 8 units (Virtual) for Waiver period	\$17.50
	2.3b Asthma Remediation and Supportive Products	Cost-based, up to cap	Up to capped amount for Waiver period	\$8,000
	2.4 Medical Respite	Per diem	Post hospitalization stay up to 90 days per year. Pre procedural care is based on the provider's directions but cannot exceed 30 days per year	\$245 - \$388
2.5 Rent / Temporary Housing	Per unit per month	Limited to 6 months for the waiver period		1-Bedroom: \$2,330 2-Bedroom: \$2,580 3-Bedroom: \$3,215 4-Bedroom: \$3,469

# SERVICE OPTIONS & FEES

Service Types	Service Name	Unit of Service	Max Units / Duration	SCN Lead Entity Rate /
Housing	2.6a Utility Setup - Activation Expenses	Cost-based, up to cap	One time, up to capped amount for Waiver period	\$350.00
	2.6b Utility Setup – Back payment	Cost-based, up to cap	One time, up to capped amount for Waiver period	\$4,566
	2.6c Utility Assistance	Cost-based, up to cap per month	Up to 6 months for Waiver period, with capped amount per month	\$761
	2.7 Pre-tenancy Services	Per 15-minutes	24 units over 6 months for Waiver period	\$18
	2.8a Community Transitional Supports (CTS)	Cost-based, up to cap	Up to capped amount for Waiver period	Studio/Efficiency: \$7,580 1-Bedroom: \$7,895 2-Bedroom: \$9,407 3-Bedroom: \$11,690 4-Bedroom: \$13,210
	2.8b CTS Broker's Fee	Cost-based, SCNlevel cap (Jan 1, 2025 – Mar 31, 2026)	One time, up to capped amount for Waiver period	Manhattan: \$40,116 Brooklyn: \$122,673 Queens: \$88,343 •SCN Lead Entity Y1 cap •SCNs determine Member rate
	2.9 Tenancy Sustaining Services	Per 15-minutes	24 units over 6 months for Waiver period	\$17.50
	2.10 Housing Transition and Navigation Services	Per 15-minutes	16 units per month up to 6 months for Waiver period	\$17.50

# SERVICE OPTIONS & FEES

Service Types	Service Name	Unit of Service	Max Units / Duration	SCN Lead Entity Rate /
Nutrition	3.1 Nutrition Counseling and Education	Per 15-minutes	8 units up to 6 months for waiver period	Initial Assessment: Re-Assessment: \$21.74
	3.2 Medically Tailored or Clinically Appropriate Home Delivered Meals	Per meal	Up to 6 months (or 11 months for high-risk pregnant / post-partum individuals). Possibility of re-authorization	\$10 - \$16
	3.3 Medically Tailored or Nutritionally Appropriate Food Prescriptions	Per week	Up to 6 months (or 11 months for high-risk pregnant / post-partum individuals). Possibility of re-authorization	\$97 - \$146
	3.4 Fresh Produce and Non-perishable Groceries (Pantry stocking)	Per week	Up to 6 months (or 11 months for high-risk pregnant / post-partum individuals). Possibility of re-authorization	\$30 - \$78
	3.5 Cooking Supplies: Kitchenware, Microwave, and Refrigerator	Cost-based, SCNlevel cap (Jan 1, 2025 – Mar 31, 2026)	Up to capped amount for Waiver period	Manhattan: \$1,055,260 Brooklyn: \$3,226,974 Queens: \$2,323,901 •SCN Lead Entity Y1 cap •SCNs determine Member rate
Transportation	4.1 Transportation	Cost-based, SCNlevel cap (Jan 1, 2025 – Mar 31, 2026)	Up to 6 months, with capped amount for Waiver period. Possibility of re-authorization	Manhattan: \$1,864,583 Brooklyn: \$5,701,871 Queens: \$4,106,196 •SCN Lead Entity Y1 cap •SCNs determine Member rate

# SERVICE DELIVERY APPROACHES

## Screening Services

- Leverage your case coordinators/intake coordinators / nurses to provide screening of your population of clients

## Navigation Services

- Use case coordinators to support navigation services.
- Hire & train Community Health Workers, Patient Navigators, and Care Managers to support navigation services.

## Enhanced Services

- Partner with non-profit and for-profit organizations to provide services.

# WORKFORCE INVESTMENT ORGANIZATIONS

AUGUST 15, 2024 | Albany, NY

## Governor Hochul Announces \$646 Million to Recruit and Train Thousands More Health Care Workers Across New York

The WIO awardees are 1199SEIU Training and Employment Funds, Iroquois Healthcare Association, and the Finger Lakes Performing Provider System.

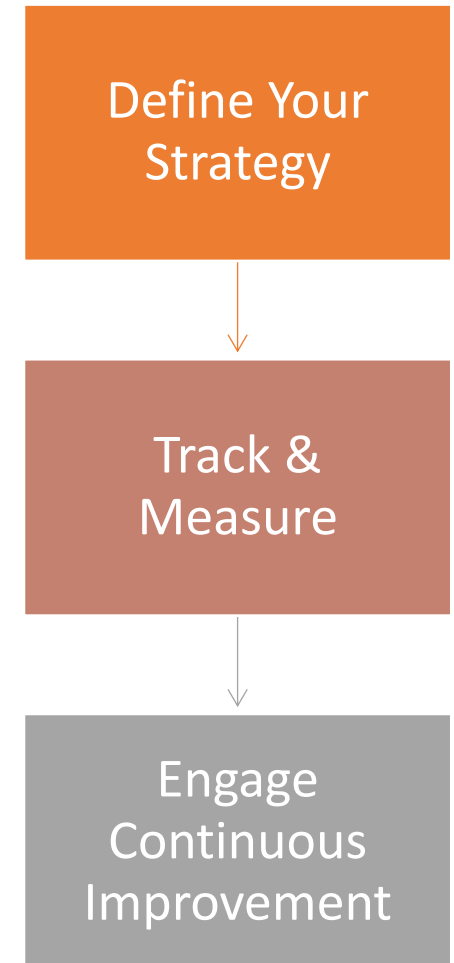
- Conduct outreach and recruit thousands of new and current health, mental health, and social care workers for participation in the **Career Pathways Training (CPT) Program**.
- Support CPT Program participants with tutoring and other academic support such as apprenticeship and mentorship programs.
- Make payments to support participants' tuition program fees, textbooks, and supplies.
- Aid in job readiness and placement to meet service commitments.
- Hold educational programs for new and current health, mental health, and social care workers, including application and enrollment assistance.
- Form partnerships with educational institutions and other stakeholders to increase career opportunities for CPT program participants.
- Perform data collection and reporting on CPT program performance metrics, spending, and other information.

# NEXT STEPS FOR HOME CARE AGENCIES



# MANAGING VALUE-BASED OUTCOMES

Percentage of members who did not have an emergency room visit in the last 90 days
Percentage of members who did not experience falls that resulted in major or minor injury in the last 90 days
Percentage of members who received an influenza vaccination in the last year
Percentage of members who did not experience uncontrolled pain
Percentage of members who were not lonely or were not distressed
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, Follow-up After hospitalization Analysis
% Of Clients that did not get hospitalized within 30 days after discharge
Reduce preventable hospitalization
Percentage of members who rated the quality of home health aide or personal care aide services within the
Percentage of members who responded that they were usually or always involved in making decisions about
Percentage of members who reported that within the last six months, the home health aide or personal care
Dental Exams Completed
Eye Exams Completed
Hearing Exams Completed
Pneumococcal Vaccine Completed



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# ADDITIONAL RESOURCES

1. **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** - <https://www.governor.ny.gov/news/governor-hochul-announces-500-million-new-social-care-networks-program-deliver-social-services>
2. **New York 1115 Medicaid Waiver Information Page** - [https://www.health.ny.gov/health\\_care/medicaid/redesign/medicaid\\_waiver\\_1115.htm](https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm)
3. **Social Care Initiatives** - [https://www.health.ny.gov/health\\_care/medicaid/redesign/sdh/](https://www.health.ny.gov/health_care/medicaid/redesign/sdh/)

# Q & A



Sherly Demosthenes-Atkinson, MHA

CEO CABS Health Network

[sdemosthenes@cabshomecare.org](mailto:sdemosthenes@cabshomecare.org)

718 388-0220 Ext 312



Kevin Howell, MBA

CEO, Anchor Group & Chief Strategic  
Consultants for CABS Health Network

[khowell@anchorgroupcorp.com](mailto:khowell@anchorgroupcorp.com)

347 413-3282



Thank You



NYS Association of  
Health Care Providers

Representing Home & Community-Based Care

Celebrating 50 Years