Introduction to the Social Care Network

A New Way to Support Medicaid Clients

Presented on March 26, 2026

What is the Social Care Network

Overview

NY Health Equity Reform (NYHER)

1115 Waiver Amendment Initiatives

Details follow

Social Care Networks (SCNs)

Improve integration across health, behavioral health, and social care

Population Health

Improve health outcomes, advance health equity, and reduce health disparities

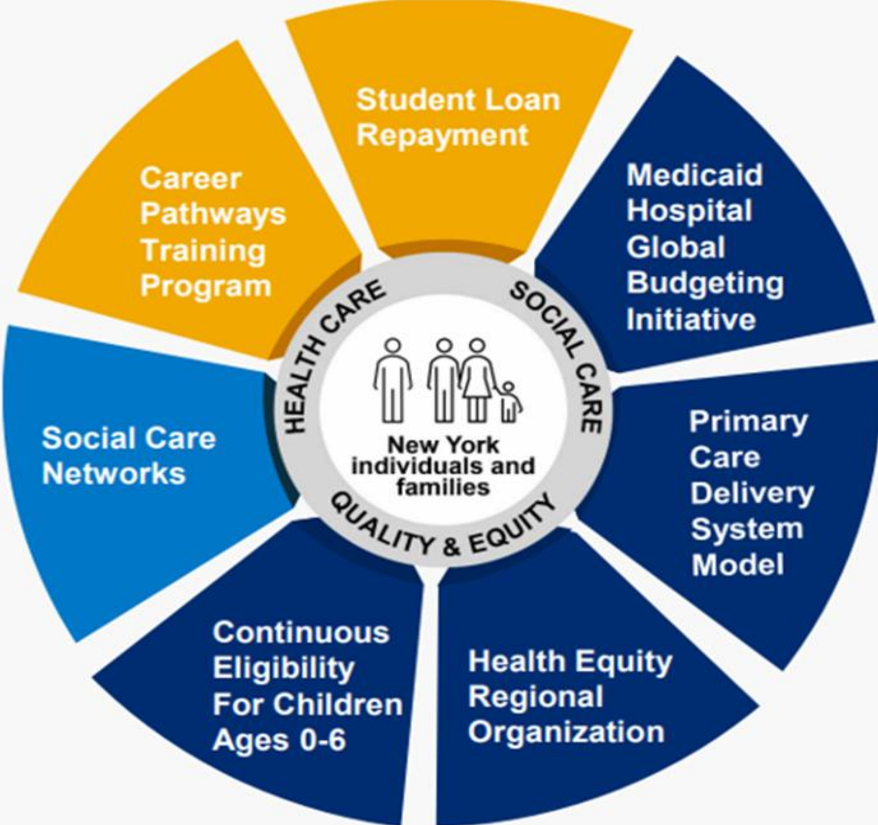
Improve financial sustainability and quality of care among safety net hospitals while strengthening primary care leveraging VBP

Enable children to remain continuously enrolled in Medicaid and Child Health Plus up to age six

Strengthening the Workforce

Fund education and professional placement services across health care, behavioral health, and social care roles

Provide loan repayment for health care professionals in under-filled roles, serving Medicaid and uninsured



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

Screening for: Unmet Enhanced Health Related Social Needs (HRSN) Services

Housing Supports

- Navigation
- Community Transitional Services
- Rent/utilities for 6 months
- Pre-tenancy (applications) & tenancy sustainability (establishing a bank account)
- Home remediation & education such as addressing mold and pest
- Home accessibility & safety modifications such as handrails and ramps, grab bars, etc.
- Medical Respite

Transportation

- Reimbursement for public and private transportation to connect to HRSN services and HRSN case management activities

Nutrition

- Nutritional counseling and classes
- Medically tailored or clinically appropriate meals home-delivered meals
- Food prescriptions
- Fruit and vegetable and nonperishables
- Cooking Supplies

Case Management

- Available to fee-for-service and managed care
- Level 1 – navigation and linkage existing State and Federal Social Services
- Level 2 – outreach, referrals, and education, including linkages to other state and federal programs
- Connections to clinical case management
- Connection to childcare, employment, education, interpersonal violence resources

Region 3: Hudson Valley
Overview

Hudson Valley

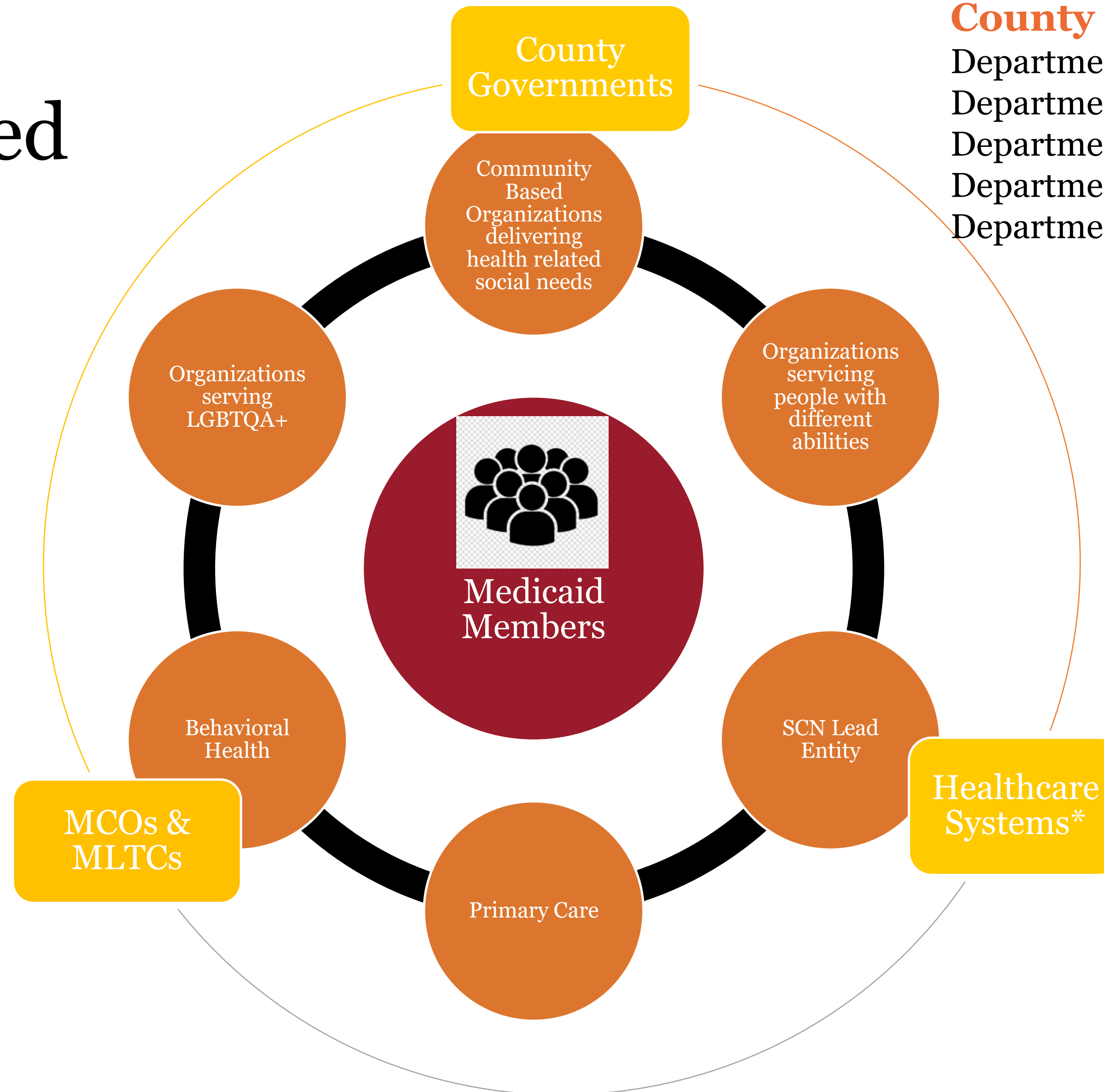
Goal: Improve health outcomes and reduce healthcare costs by addressing social determinants of health through a coordinated, whole-person care model

Counties Covered: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

Over 600,000 attributed Medicaid member lives to be screened

Funding & Reimbursement: Services are reimbursed through Medicaid Managed Care plans via the Social Care Network (SCN) Lead Entity – Hudson Valley Care Coalition

Hudson Valley's Community Based Healthcare Eco-System



County Governments
Department of Mental Health
Department of Social Services
Department of Health
Department of Aging
Department Office for People with Disabilities

Healthcare Systems
Ambulatory practices
Discharge Planners
Emergency Departments
Hospitals

MCO = Managed Care Organizations
MLTC = Managed Long-Term Care

Hudson Valley Care Coalition

Care in Every Connection

Current Network Development

Over 150 Community Based Organizations have contracted with HVCC to provide Health Related Social Needs (HRSN) related services

- Screening
- Navigating/Care Managers
- Accepting Referrals and Providing Services

System Hospitals + Primary Care Integration

- Joining our Network and screening and in some cases even navigating and providing services
- Others are referring to our Community Based Organizations, and we are discussing co-location service opportunities

County + Local Government participation on our IT Platform

- Allows for easier access for referrals that existed before SCN and are still available

HudsonValley Care COALITION

Outreach and Education Plan

Education + Raising Awareness

- Resources offered through the SCN
- Messaging is simple and impactful and relatable with visuals

Partnerships + Collaboration

- Attend community events and activities to build relationships with Members, organizations, and raise awareness on the resources

Impact + Outcomes

- Highlight success stories. Share compelling narratives of individuals and families who have benefited from programs
- Present data and statistics
- Showcase community impact

Current Nutritional Need Data

2025 Results:

- Total Screenings: 25,155
- Members with Unmet Needs: 21,413
- Members with unmet Nutritional need: 75%

61 Nutritional Providers in HVCC network

- 36 Nutritional providers in Westchester County
  - Saw uptick with member screenings with concern around SNAP & Medicaid cuts

Nutrition

- Nutritional counseling and classes
- Medically tailored or clinically appropriate meals home-delivered meals
- Food prescriptions
- Fruit and vegetable and nonperishables
- Cooking Supplies

Current Housing Supports Need Data

2025 Results:

- Total Screenings: 25,155
- Members with Unmet Needs: 21,413
- Members with unmet Housing need: 60%

48 Housing Assistance providers in HVCC network

- 19 Housing Assistance providers in Westchester County

Housing Supports

- Navigation
- Community Transitional Services
- Rent/utilities for 6 months
- Pre-tency (applications) & tenancy sustainability (establishing a bank account)
- Home remediation & education such as addressing mold and pest
- Home accessibility & safety modifications such as handrails and ramps, grab bars, etc.
- Medical Respite

Real Stories, Real Impact:

Comprehensive social support for Simone and her family

Simone was referred to Supportive Futures Foundation through her care manager at Achieve during a period of acute instability. At the time of referral, she was facing an active eviction proceeding, experiencing financial strain, food insecurity, utility shut-off risk, and elevated household stress impacting family functioning.

Through a comprehensive Social Care Network assessment, the following needs were identified and addressed: Housing Stability, Utility Assistance, Food Insecurity, and Social and Family Support

- To address food insecurity, Simone and her family were enrolled in weekly home-delivered meals, ensuring consistent access to nutritious food.
- For housing instability, SFF coordinated closely with Legal Aid, the landlord, and the landlord's attorney. Our team gathered required documentation, supported communication between parties, and facilitated payment of rental arrears, resulting in the halt of eviction proceedings.
- In addition, one-time utility assistance was provided to prevent service shut-off during this critical period.

Outcomes & Day-to-Day Impact

With stabilized housing, food security, and utilities in place, Simone reported significantly reduced daily stress. The family was able to resume regular rent payments and implement improved budgeting practices with guidance from SFF staff. As financial and housing pressures decreased, Simone shared that household relationships improved, allowing her and her partner to focus on family stability and remain together.

Driving Member Outcomes using Whole-Health Approach

Continuing to deepen coordination with housing, nutritional, and transportation providers to expand ecosystem.

Streamlining resource allocation

Improving health equity by reaching underserved populations

What You Can Do

Overview

What You Can Do

Join the **Hudson Valley's Social Care Network**

- **Provide referrals for clients**
- **Help us educate others about the Social Care Network**

Thank You!

Appendix

HVCC Staff Contact Information

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