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PRIMARY CARE

PCMH participation in Social Care Networks

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Dear Patient Centered Medical Home (PCMH) Providers,

The NYS Office of Health Insurance Programs (OHIP) launched the Social Care Network (SCN) program almost a year and a half ago to ensure that the health-related social needs (HRSNs) of Medicaid members are consistently identified and addressed in order to improve health outcomes. As a reminder, since April 1, 2026, primary care providers recognized under the NYS Patient Centered Medical Home (PCMH) program who have also signed an attestation to work with SCNs and conduct the required PCMH quality data reporting must do so to continue to receive the incentive enhancement paid by NYS DOH. SCNs provide critical services that can improve the health outcomes of your patients. This includes **nutrition, housing, transportation, and care management.** SCNs have screened over 1M Medicaid members so far. Types of involvement from PCMH practices include:

1. Screen Medicaid members with the Accountable Health Communities Health Related Social Need screening Tool and submit the screenings either through your EHR, to a regional Qualified Entity, or directly to the Social Care Network through their designated Social Care IT Platform (eligible for additional payment from SCN)
2. Contract with a regional SCN to have the network embed navigators
3. Provide marketing materials to members that include self-screening links from the Social Care Network or a process that allows a direct referral or warm hand off to a Social Care Network Navigator

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