

Collection of Health-Related Social Needs Data among State Medicaid Agencies and Managed Care Organizations

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From September to December 2022, NORC conducted semi-structured virtual interviews with states and health plans to understand their health equity-related data collection efforts and initiatives, successes, and challenges. This brief presents findings related to collection of health-related social needs data to advance health equity in Medicaid.

This brief draws from findings from a full report related to the collection of data to advance health equity, available [here](#).

Health-related social needs (HRSN) are individual-level needs based on broader, systemic social determinants of health.¹ Addressing HRSN mitigates and reduces disparities in health outcomes.² State Medicaid agencies and MCOs, as providers of healthcare coverage and delivery of care for individuals with low incomes,^{3,4} are best positioned to develop innovative strategies to promote health equity, starting with data collection. Improving the quality and availability of data on HRSN equips state Medicaid agencies and Medicaid managed care organizations (MCOs) with the information they need to address the needs of the people they serve. To better understand current activities, opportunities, and potential barriers to addressing HRSN in Medicaid programs, NORC conducted interviews with 26 representatives from 12 states and 10 representatives from 5 MCOs from September to December 2022.

STATE EFFORTS TO IMPROVE HRSN DATA COLLECTION

States and health plans described implementing various efforts to improve collection of HRSN data, including:

Tracking enrollee HRSN, including by race, ethnicity, and sexual orientation and gender identify (SOGI). As part of its section 1115 demonstration, **Minnesota** provides food assistance to Medicaid recipients' children who have identified food insecurity needs. Under this

initiative, **Minnesota** measures how many children receive meals. **Oregon** disaggregates their social needs metrics at the health plan level by race and ethnicity, with the goal of improving their understanding of where inequities exist for their members and how to eliminate them. Oregon's three primary areas of interest are housing, food insecurity, and transportation. The state hopes to use the disaggregated data to inform their Medicaid policies and services.

Exploring ways to directly incentivize providers and MCOs to conduct HRSN screening and collect HRSN data. To move providers and MCOs toward greater HRSN data collection or social risk factor screenings, states are linking associated activities and processes to incentives or reimbursement. For its Section 1115 demonstration, **MassHealth**, Massachusetts's Medicaid program, collects data on food and housing insecurity at the enrollee level. The state adjusts capitated rates to accountable care organizations (ACOs) for social risk, including homelessness status captured via Z code or by the presence of three or more addresses in the state's administrative record for an enrollee within a year. In the future, the state hopes to tie hospital performance on these measures to hospital-level incentives to reduce disparities. **Tennessee** providers in Health Starts Provider Partnerships are required to use Z codes to track enrollees' social needs. The provider initiative focuses on

payment models to integrate HRSN into systems of care and report findings back with the community and partners through a closed-loop referral process.

Linking Medicaid data to data from other state

agencies. States supplement their Medicaid data with data from other state agencies including vital records, child welfare information, other health information, and data from programs like Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Women, Infant, and Children (WIC), and Low Income Home Energy Assistance Program (LIHEAP). These data sources help states gain a more comprehensive picture of Medicaid enrollees' HRSN.

California leverages its connection to state programs such as TANF and SNAP to get a snapshot of food insecurity among their enrollees. **Pennsylvania's** data warehouse uses a unique identifier to track services its Medicaid enrollees use across state agencies, including child welfare, SNAP, TANF, LIHEAP, and housing assistance programs. **Washington State** is working with the Department of Commerce and other partners through data sharing to create analytical projects.

Linking Medicaid data to other external data sources.

Use of publicly available data sources can help Medicaid agencies and MCOs better understand enrollees' social needs, experiences, and community resources.

Neighborhood Health Plan of Rhode Island uses publicly available geospatial information and mapping to understand transportation barriers in lieu of having a complete dataset on member needs for transportation support. **Washington State** is exploring multiple external data sources such as IBM Watson, American Community Survey, and census data to understand the HRSN of their members. In addition, Washington State has partnerships with the University of Washington where they are using modeling tools to analyze the impacts of climate change within the Medicaid population, and a partnership with their enterprise data warehouse to geo-code their information for future use in other initiatives.

Leveraging use of existing community referral

systems. Some states established relationships with, or are considering, vendors like FindHelp, Unite Us, and CrossTx that have existing referral platforms for social services. States and MCOs noted that these vendors have the capacity to screen and refer enrollees to services while reporting data back to MCOs. Florida's **Community Care Plan** is interested in aligning their case management platform with a platform like FindHelp to close their referral feedback loop. **Tennessee** notes that with the use of systems such as FindHelp, MCOs can receive data and information on their member's social needs.

Considering National Committee for Quality Assurance (NCQA) Health Equity Accreditation.⁵

NCQA launched the Health Equity Accreditation program in fall 2021. Some states view the new Health Equity Accreditation as a more robust accreditation framework that ties race and ethnicity data collection with HRSN needs and community partnership. **Community Care Plan** and **Neighborhood Health Plan of Rhode Island** are upgrading their case management systems and data infrastructures to better prepare them to meet standards when they pursue Health Equity Accreditation. **South Carolina** requires contracted MCOs to obtain Health Equity Accreditation.

Engaging community members to improve data

quality. Tools and systems to collect, refer, and track HRSN data should be informed by community members. **Health Plan of San Joaquin** has a "community affairs committee" composed of plan staff and local community members who meet to bi-directionally share information and feedback on community-level interventions. Also, the plan is increasingly meeting with community-based organizations, local housing authorities, and local police departments to discuss interventions and ways to support people at-risk for incarceration. **Michigan** has the Community Health Innovation Regions, a social care model designed to have "community conversations" about what the data are showing for enrollees' communities and to better understand enrollees' social needs. **Minnesota** is funding programs with strong community engagement components to better meet the community's needs and be more responsive to communities they serve, particularly those who face structural racism and structural inequity.

KEY CHALLENGES

A lack of standards for tracking and reporting HRSN leads to a fragmented or incomplete understanding of enrollee-level needs.

Providers use different screening tools, data collection systems, and platforms for making and tracking social needs referrals. While it is important to enable providers and health systems to implement tools that fit their patient needs and care management workflows, this lack of standardization makes it challenging to get a state-level understanding of enrollees' HRSN and the extent to which those needs are being met. **Michigan** attempted to implement a standard social need screening tool as part of its quality withholding strategy for MCOs for fiscal years 2020 and 2021. However, the state eliminated its use because they heard from providers that it was not capturing accurate, usable data and, therefore, was not appropriate for setting benchmarks at the state level. The state then engaged a public health institute to redesign the tool in a way that aligns with HEDIS measures on HRSN,

with the goal of maximizing utility and reducing burden for collecting this data.

Interviewees called for a more systematic and comprehensive way of collecting and tracking HRSN data that can also be shared between entities. Standardizing domains allows for interoperability among data systems, resulting in data exchange among different entities like states, MCOs, and providers. Standards for the method of data collection and sharing of HRSN can help MCOs and providers obtain a more thorough understanding and representation of the social needs of their members; identify gaps in health outcomes; and facilitate the tracking of these referrals.

A lack of requirements, incentives, and standard practices for Z codes limits their use as a standardized way of reporting HRSN. Z codes are ICD-10 codes that providers can use to report HRSN on claims data.⁶ They can identify a range of social, economic, environmental, and occupational factors related to health. While Z codes could be a useful tool for standardizing this information on Medicaid claims data, various state and plan interviewees noted that providers often lack sufficient incentives to capture and report data on HRSN to MCOs or state Medicaid agencies. Z codes are not tied to provider incentives, even if they are submitted on a claim for billing. They also do not fully capture all the types of needs that may be identified in screening, such as transportation or childcare. Additionally, Z codes have subcategories that provide more specificity about identified needs but are oftentimes not captured by providers. Thus, overall provider use of Z codes is limited.⁷ States and health plans called for more guidance and technical support to increase Z codes use.

In 2022, NORC assessed the documentation of social needs using Z codes in Medicaid T-MSIS data. Few providers document enrollee social needs using Z codes in Medicaid claims and encounter data.

Provider and enrollee concerns about how social need data is used create resistance for its collection. Some providers have concerns that collecting HRSN is burdensome and can lead to liability fears. For example, providers may not have adequate resources or referral networks in place to support their patients once a social need is identified via screening. This may be particularly sensitive with issues like domestic violence and homelessness; providers may therefore feel it is negligent to ask about these needs without having the ability to refer individuals to adequate services. Enrollees are also concerned that reporting food insecurity, housing, or other needs could put them at risk for child welfare interventions due to mandatory reporting.

Limitations technological capacity to capture HRSN and support closed-loop referral systems lead to more limited data collection. Provider sharing of referral

information to the state, MCO, or other providers is case-by-case or for a specific intervention, program, or health condition. States generally do not have a universal system (i.e., one single platform used for all HRSN screening or referrals to services across a state) for coordinating care or sharing information across systems and providers. Some states use community referral platforms, but these often do not connect back to electronic health records (EHRs). Thus, states and providers cannot consistently track which enrollees need services or if they have received support for those needs. Many state interviewees noted they wish they had a closed-loop tracking and referral system to better understand their enrollees' HRSN.

“What we don’t currently have in place is systematic data collection... I would love to see a process whereby social risk factor questions become embedded as part of the standard screenings that Medicaid members get no matter where they go... And for there to be standard mechanisms that, as that gets recorded in the physician’s EHR or wherever they might be, that it translates into that Z code that then drops into the claim or encounter.

Systematization of this process is twofold. 1) It’s about the systems that capture and relay the data, that it’s built into the workflow in a systematic way so it’s always asked of members, no matter where they present for their healthcare. 2) As this data starts to get collected or reported systematically... how do we build standard processes or ways in which the needs that are identified then get referred out to community partners who can then meet those needs and for there to be a bidirectional loop back.”

– State of Hawaii, Department of Health and Human Services, Med-QUEST Division

Methodology

From September to December 2022, NORC conducted semi-structured virtual interviews with 26 representatives from 12 states and 10 representatives from 5 health plans. NORC selected states based on geographic and Medicaid program diversity and known information about Medicaid program progress in advancing health equity. NORC worked with the Association of Community Affiliated Plans (ACAP) to identify health plans for the interviews.

Topics of discussion included:

- Data collection efforts states and plans were engaged in to support measurement and oversight of health equity goals in Medicaid
- How states and plans were developing data collection systems to monitor health equity measures, e.g., health disparities, social risk factors, and demographics like race, ethnicity, and language
- Success/facilitators and challenges/barriers states and health plans were facing when developing or implementing data and systems-level approaches to collecting health-related social needs and race, ethnicity, language data
- Additional policies and supports states and health plans need to improve their data collection efforts to advance health equity

Each interview was recorded for note-taking purposes. To analyze the data, NORC used NVivo qualitative data software to code each transcript. NORC developed a code book inductively based on the interview guides and research questions and updated the codebook inductively based on emerging themes from the coding process. The NORC team conducted thematic analysis of the themes to synthesize findings.

Participating states: California, Florida, Hawaii, Massachusetts, Michigan, Minnesota, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Washington

Participating health plans: CareOregon, Community Care Plan, Health Plan of San Joaquin, Hennepin Health, Neighborhood Health Plan of Rhode Island

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¹ "When Talking About Social Determinants, Precision Matters", Health Affairs Blog, October 29, 2019. DOI: 10.1377/hblog20191025.776011

² Artiga, S., & Hinton, E. (2019). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. *Health*, 20(10), 1–13.

³ Chisolm, D. J., Brook, D. L., Applegate, M. S., & Kelleher, K. J. (2019). Social determinants of health priorities of state Medicaid programs. *BMC Health Services Research*, 19(1), 167. <https://doi.org/10.1186/s12913-019-3977-5>

⁴ Guth, M., & Artiga, S. (2022). Medicaid and Racial Health Equity. San Francisco, CA: Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/>

⁵ National Committee for Quality Assurance. *Health Equity Accreditation*. NCQA. Published 2023. Accessed April 19, 2023. <https://www.ncqa.org/programs/health-equity-accreditation/>

⁶ Center for Medicare and Medicaid Services. *Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019*. 2021;Data Highlight(24). <https://www.cms.gov/files/document/z-codes-data-highlight.pdf>

⁷ Ubri P.S., Swietek K, Sawyer J, Pyatt T, Stead M. *Use of ICD-10-CM Z Codes in 2018 Medicaid Claims and Encounter Data*. NORC at the University of Chicago; 2022:1-20. Accessed April 19, 2023. https://www.norc.org/PDFs/Documentation%20of%20Social%20Needs%20in%202018%20Medicaid%20Data/Documentation%20of%20SDOH%20in%20Medicaid%20Claims_032422.pdf