Proposed Changes to Existing Measure for HEDIS®[1] MY 2026: Social Need Screening and Intervention (SNS-E)

NCQA seeks comments on a proposed measure update for inclusion in HEDIS Measurement Year (MY) 2026.

Social Need Screening and Intervention (SNS-E): The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using prespecified instruments and, if screened positive, received a corresponding intervention. Six rates are reported:

- *Food screening*: The percentage of members who had a screening for unmet food needs.
- *Food intervention*: The percentage of members receiving a corresponding intervention within 1 month of screening positive for unmet food needs.
- *Housing screening*: The percentage of members who had a screening for unmet housing needs.
- *Housing intervention*: The percentage of members receiving a corresponding intervention within 1 month of screening positive for unmet housing needs.
- *Transportation screening*: The percentage of members who had a screening for unmet transportation needs.
- *Transportation intervention*: The percentage of members receiving a corresponding intervention within 1 month of screening positive for unmet transportation needs.

The measure excludes individuals in hospice, enrolled in Institutional Special Needs Plans (I-SNP) or residing in long-term care institutions. The measure is stratified by age (≤17, 18–64, 65+). Screening instruments and intervention codes in the measure align with the Gravity Project, a multi-stakeholder, public collective initiative aimed at developing standardized terminology for documentation and exchange of social determinants of health (SDOH) data.

SNS-E was published in HEDIS for MY 2023 as a first-year measure. To satisfy the screening requirement, submission of a Logical Observation Identifiers Names and Codes (LOINC) code from an approved, evidence-based tool aligned with the Gravity Project is required for the screening numerator. To meet the denominator of the intervention indicator, a positive screen associated with a LOINC code is necessary. For the numerator of the intervention indicator, applicable Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT) and Current Procedural Terminology (CPT) codes are required. The first-year analysis (summer 2024) revealed that submitting administrative codes was easier than relying solely on EHR data. Health plans face challenges in extracting LOINC codes from EHRs, as they can more readily access administrative or case management data. NCQA saw this as an opportunity to explore whether adding new Healthcare Common Procedure Coding System (HCPCS) G and International Classification of Diseases, Tenth Revision (ICD-10) Z codes could improve plans' ability to report performance data.

The implementation of Z codes and G codes marks a significant advancement in capturing SDOH that affect patient care and outcomes. Despite their introduction in 2015 and subsequent expansions in 2021 and 2023, the documentation and utilization of these codes remain low. Ongoing efforts by CMS to enhance SDOH data collection—through mandating social need screenings in various programs and introducing reimbursement policy for standardized assessments—are crucial for advancing health equity and improving overall health care quality.[2] NCQA strives to align with ongoing efforts in the field of SDOH collection and documentation, and therefore is evaluating the addition of relevant administrative codes (G and Z) into the SNS-E measure.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] Centers for Medicare & Medicaid Services. *CMS Framework for Health Equity 2022–2032.* https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework

Add G0136 Assessment Code to the Screening Numerator. NCQA proposes adding G0136 ("Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months") to food, housing and transportation screening indicators.[3] Thus, the description of screening indicators would be modified to be "the percentage of members who had a screening or were assessed by a provider for unmet needs." Preliminary results from January–June 2024 data from Optum Labs Data Warehouse demonstrate that the G code is used in Medicare and commercial product lines, and utilization will likely increase.

NCQA acknowledges the potential physician burden associated with adding provider assessments such as G0136. However, assessments align with work already being done, in practice, and could help reduce duplication of services by streamlining inclusion of SDOH data, ultimately minimizing redundant efforts. Additionally, including the G code does not replace the option for health plans to submit LOINC codes to meet the screening numerator. Because this is a population-level measure, it is anticipated that most initial screenings will continue to be conducted by ancillary staff or through technological methods designed to capture screenings effectively.

A Z code is not being considered for the screening numerator, as the intent of this indicator is to capture that a screening or assessment was performed, not the screening result. A member with a documented Z code must have undergone a screening and/or clinical assessment to receive the Z code and will already be captured in the numerator of this screening indicator.

Add Z Codes to Intervention Denominator. NCQA proposes adding relevant Z codes (for example, Z59.41 Food Insecurity, Z59.1 Inadequate Housing, Z59.82 Transportation Insecurity) to the appropriate intervention indicator denominators. The intervention denominator captures that a social need was identified. Thus, a description of intervention indicators would be modified to be "the percentage of members receiving a corresponding intervention within 1 month of an identified need." Individuals with identified needs would be captured through a positive result on a standardized screening *or* with a documented Z code.

Preliminary results from January–June 2024 data from initial testing in Medicare and Commercial data demonstrate that Z code utilization is low. The most documented Z code for commercial plans was Z59.41 (food insecurity), and for Medicare plans was Z59.82 (transportation insecurity). These findings differ from previous utilization studies on Z codes demonstrating that housing-related needs were the most documented. This suggests that utilization of Z codes is increasing, along with recent policy efforts in the 2024 Physician Fee Schedule encouraging documentation of both G and Z codes. Relevant ICD-10 Z codes could be useful for identifying individuals with social needs for SNS-E intervention indicators.

Add G codes (G0019, G0023, G0140) to the Intervention Numerator. NCQA proposes adding G0019 ("Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s)") to the numerator of the food screening, housing screening and transportation intervention indicators. NCQA also proposes adding G0023 and G0140 ("Principal illness navigation services") to the intervention indicator numerators. These codes were introduced in the 2024 Physician Fee Schedule, and capture services provided by ancillary personnel in addressing social needs. They recognize and formalize the critical role non-clinical staff, such as community health workers and care coordinators, play in identifying and addressing SDOH, and capture a more holistic view of services provided.

Remove "Assessments" from the Intervention Numerator. NCQA proposes removing assessments from the list of allowable interventions and related value sets. The intervention indicator currently captures eight broad categories of intervention types, including assessment. To better align with the

[3] Federal Register. (2024). *Medicare and Medicaid programs; CY 2025 payment policies under the physician fee schedule and other revisions to part B (CMS-XXXX-P).* Federal Register, 89(236). https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other

Gravity Project and HL7 International Conceptual Framework for SDOH Clinical Care, the assessment category will be removed as an allowable intervention. As a result, CPT codes 96161, 96160 and 96156 will be removed from the value sets for food, housing and transportation interventions. Intervention categories will now be consolidated into seven broad categories: assistance, counseling, coordination, education, evaluation of eligibility, provision, referral.

The assessment activity will instead align with screening efforts and be added to the screening numerator, referencing the G0136 code. The CPT codes 96161, 96160 and 96156 will not be added to the screening numerator, because they are not unique to addressing social needs. These updates aim to improve the clarity and alignment of the measure with established SDOH frameworks, ensuring more accurate tracking of interventions.

NCQA seeks specific feedback on the following:

1. Adding G0136 to count towards screening indicators.
2. Adding Z codes to identify individuals with social needs for intervention indicators.
3. Adding G codes (G0019, G0023, G0140) to the intervention numerator.
4. Removing “assessments” from the intervention numerator.
5. Ensuring that updates deliver meaningful benefits and improved support for patients.

NCQA expert panel members support the proposed measure updates and believe it is an important step toward improving data collection and reporting of SDOH data and addressing the social needs of members.

Supporting documents include the updated measure specifications and the literature review on G and Z codes.

NCQA acknowledges the contributions of the Health Equity Expert Work Group and the Geriatric and Technical Measurement Advisory Panels.

Measure title	Social Need Screening and Intervention	Measure ID	SNS-E
Description	• The percentage of persons who were screened~~,~~ using prespecified instruments, or assessed by a provider, for unmet food, housing, and transportation needs at least once during the measurement period. The percentage of persons, with an identified need or positive screen, who received a corresponding intervention. – *Food Screening.* The percentage of persons who were screened, or assessed by a provider, for food insecurity. – *Food Intervention.* The percentage of persons who received a corresponding intervention within 30 days (1 month) of an identified food need or positive screen for food insecurity. – *Housing Screening.* The percentage of persons who were screened, or assessed by a provider, for housing instability, homelessness or housing inadequacy. – *Housing Intervention.* The percentage of persons who received a corresponding intervention within 30 days (1 month) of an identified housing need or positive housing screen. – *Transportation Screening.* The percentage of persons who were screened, or assessed by a provider, for transportation insecurity. – *Transportation Intervention.* The percentage of persons who received a corresponding intervention within 30 days (1 month) of, an identified transportation need or positive screen for transportation insecurity.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org. Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement and rationale	The American Academy of Family Physicians urges health insurers and payers to provide appropriate payment to support health care practices to identify, monitor, assess and address SDOH. The American Academy of Pediatrics recommends surveillance for risk factors related to social determinants of health during all patient encounters. The American Diabetes Association recommends assessing food insecurity, housing insecurity/homelessness, financial barriers and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources.		
Citations	American Academy of Family Physicians. 2019. “Advancing Health Equity by Addressing the Social Determinants of Health in Family Medicine (Position		

	Paper).” https://www.aafp.org/about/policies/all/social-determinants-health-family-medicine-position-paper.html American Academy of Pediatrics. 2016. “Poverty and Child Health in the United States.” https://pediatrics.aappublications.org/content/137/4/e20160339#sec-12 American Diabetes Association. 2022. “Standards of Medical Care in Diabetes-2022.” *Diabetes Care 45(Suppl 1)* S4–7. DOI:10.2337/dc22-Srev The Gravity Project. “Terminology Workstream Dashboard.” The Gravity Project Confluence, n.d. https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard
Characteristics	
Scoring	Proportion.
Type	Process.
Product lines	• Commercial. • Medicaid. • Medicare.
Stratifications	Age as of the start of the measurement period. • ≤17 years. • 18–64 years. • 65 years and older.
Risk adjustment	None.
Improvement notation	Increased score indicates improvement.
Guidance	**Data collection methodology**: ECDS. Refer to the General Guideline: Data Collection Methods for additional information. **Date specificity:** Dates must be specific enough to determine the event occurred in the period being measured. **What services count?** When using claims, include all paid, suspended, pending and denied claims. When using SNOMED-CT codes to identify history of a procedure, the date of the procedure must be available.
Definitions	
Food insecurity	Uncertain, limited or unstable access to food that is adequate in quantity and in nutritional quality, culturally acceptable, safe and acquired in socially acceptable ways.

<table>
<tr><td>Housing instability</td><td>Currently consistently housed, however may have experienced any of the following circumstances in the past 365 days: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.</td></tr>
<tr><td>Homelessness</td><td>Currently living in an environment that is not meant for permanent human habitation (e.g., car, park, sidewalk, abandoned building, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.</td></tr>
<tr><td>Housing inadequacy</td><td>Housing does not meet habitability standards.</td></tr>
<tr><td>Transportation insecurity</td><td>Uncertain, limited or no access to safe, reliable, accessible, affordable and socially acceptable transportation infrastructure and modalities necessary for maintaining one’s health, well-being or livelihood.</td></tr>
<tr><td>Food Insecurity Screening Instruments</td><td>Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Food Insecurity Instruments</th><th>Screening Item LOINC Codes</th><th>Positive Finding LOINC Codes</th></tr>
<tr><td rowspan="2">Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool</td><td>88122-7</td><td>LA28397-0
LA6729-3</td></tr>
<tr><td>88123-5</td><td>LA28397-0
LA6729-3</td></tr>
<tr><td rowspan="2">American Academy of Family Physicians (AAFP) Social Needs Screening Tool</td><td>88122-7</td><td>LA28397-0
LA6729-3</td></tr>
<tr><td>88123-5</td><td>LA28397-0
LA6729-3</td></tr>
<tr><td rowspan="2">American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form</td><td>88122-7</td><td>LA28397-0
LA6729-3</td></tr>
<tr><td>88123-5</td><td>LA28397-0
LA6729-3</td></tr>
<tr><td>Health Leads Screening Panel®[1]</td><td>95251-5</td><td>LA33-6</td></tr>
<tr><td>Hunger Vital Sign™[1] (HVS)</td><td>88124-3</td><td>LA19952-3</td></tr>
<tr><td>Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]</td><td>93031-3</td><td>LA30125-1</td></tr>
<tr><td rowspan="2">Safe Environment for Every Kid (SEEK)®[1]</td><td>95400-8</td><td>LA33-6</td></tr>
<tr><td>95399-2</td><td>LA33-6</td></tr>
<tr><td>U.S. Household Food Security Survey [U.S. FSS]</td><td>95264-8</td><td>LA30985-8
LA30986-6</td></tr>
<tr><td>U.S. Adult Food Security Survey [U.S. FSS]</td><td>95264-8</td><td>LA30985-8
LA30986-6</td></tr>
</table></td></tr>
</table>

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Housing Instability, Homelessness and Housing Inadequacy Screening Instruments

Eligible screening instruments with thresholds for positive findings include:

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	71802-3	LA31994-9 LA31995-6
Children's Health Watch Housing Stability Vital Signs™[1]	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel®[1]	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
Norwalk Community Health Center Screening Tool [NCHC]	99134-9	LA33-6
	99135-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

[1]Proprietary; may be cost or licensing requirement associated with use.

Transportation Insecurity Screening Instruments

Eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form	99594-4	LA33093-8 LA30134-3
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®[1]	99553-0	LA33-6
Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Discharge from Agency [CMS Assessment]	101351-5	LA30133-5 LA30134-3

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Outcome and assessment information set (OASIS) form—version E—Resumption of Care [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS Assessment]	101351-5	LA30133-5 LA30134-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93030-5	LA30133-5 LA30134-3
PROMIS®[1]	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

~~***Note:** The SNS-E screening numerator counts only screenings that use instruments in the measure specification, as identified by the associated LOINC code(s). Allowed screening instruments and LOINC codes for each social need domain are listed above.*~~

NCQA recognizes that organizations might need to adapt or modify instruments to meet the needs of their membership. To clarify:

- The SNS-E measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators.

  ~~Only screenings documented using the LOINC codes specified in the SNS-E measure count toward the measure's screening numerators.~~
- The Regenstrief Institute, which maintains the LOINC database, has indicated that LOINC codes are not developed at the level of granularity that distinguishes between original and adapted or translated instruments.
- Tool developers have varying policies with regard to cultural adaptation and translations; some state that users may adapt screening instruments, others state that organizations must obtain permission first. NCQA urges organizations to refer to the tool developer for information about adaptations or translations that are available or allowed.

Interventions

An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period.

- An identified ~~positive~~ food ~~insecurity~~need, or positive food insecurity screen finding, must be met by a food insecurity intervention.
- An identified housing instability or homelessness need, or positive housing instability or homelessness screen finding, must be met by a housing instability or ~~-~~homelessness intervention.
- An identified housing inadequacy need, or positive housing inadequacy screen finding, must be met by a housing inadequacy intervention.

	• An identified ~~positive~~ transportation need, or positive transportation insecurity screen finding, must be met by a transportation insecurity intervention. Interventions may include assistance, ~~assessment~~, counseling, coordination, education, evaluation of eligibility, provision or referral.

Initial population	*Measure item count:* Person. *Attribution basis:* Enrollment. • *Benefit:* Medical. • *Continuous enrollment:* The measurement period. • *Allowable gap:* No more than one gap of ≤45 days during the measurement period. ~~-~~No gaps on the last day of the measurement period. *Ages:* 0+ as of the start of the measurement period. *Event:* None.
Denominator exclusions	• **Persons with a date of death.** Death in the measurement period, identified using data sources determined by the organization. Method and data sources are subject to review during the HEDIS audit. • **Persons in hospice or using hospice services.** Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file. • **Persons who are 66 years of age and older by the last day of the measurement period, with Medicare benefits, enrolled in an institutional SNP (I-SNP) or living long-term in an institution (LTI).** Persons enrolled in an Institutional SNP (I-SNP) any time during the measurement period. Living long-term in an institution any time during the measurement period as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement period.
Denominator	**Denominators 1, 3, 5:** The initial population minus denominator exclusions. **Denominator 2:** All persons in numerator 1 with an identified food need (Food Insecurity Value Set), or a positive food insecurity screen finding, between January 1 and December 1 of the measurement period. **Denominator 4:** All persons in numerator 3 with an identified ~~-~~housing need (Housing Instability Value Set; Homelessness Value Set; Housing Inadequacy Value Set) or a housing instability, homelessness or housing inadequacy screen finding, between January 1 and December 1 of the measurement period.

	Denominator 6: All persons in numerator 5 with an identified transportation need (ICD10CM code Z59.82), or a positive transportation insecurity screen finding, between January 1 and December 1 of the measurement period.
Numerator	**Numerator 1—Food Screening** Persons in denominator 1 with a documented result for food insecurity screening, or assessment by a provider (HCPCS code G0136), performed between January 1 and December 1 of the measurement period. **Numerator 2—Food Intervention** Persons in denominator 2 who received a food insecurity intervention (Food Insecurity Procedures Value Set) on or up to 30 days after the date of the first food need identified or positive food insecurity screen (31 days total). **Numerator 3—Housing Screening** Persons in denominator 3 with a documented result for housing instability, homelessness or housing inadequacy screening, or assessment by a provider (HCPCS code G0136), performed between January 1 and December 1 of the measurement period. **Numerator 4—Housing Intervention** Persons in denominator 4 who received an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first housing need identified or positive housing screen (31 days total). • Housing Instability Intervention (Housing Instability Procedures Value Set). • Homelessness Intervention (Homelessness Procedures Value Set). • Housing Inadequacy Intervention (Inadequate Housing Procedures Value Set). **Numerator 5—Transportation Screening** Persons in denominator 5 with a documented result for transportation insecurity screening, or assessment by a provider (HCPCS code G0136), performed between January 1 and December 1 of the measurement period. **Numerator 6—Transportation Intervention** Persons in denominator 6 who received a transportation insecurity intervention (Transportation Insecurity Procedures Value Set) on or up to 30 days after the date of the first transportation need identified or positive transportation screen (31 days total).
Summary of changes	• Removed the definitions of participation and participation period. These definitions have been integrated into the measure where applicable. • Added HCPCS code G0136 to screening numerator for identifying provider assessments. • Added diagnostic codes to intervention denominators for identifying individuals with positive social needs. • Removed assessments from allowable interventions. • Added principal navigator service codes to allowable interventions.

	• Removed the source system of record (SSoR) exclusions data elements from the data elements tables.

Data element tables

Source System of Record

Numerator data are submitted by each SSoR accessed to produce the measure result. The SSoR is the authoritative dataset; it contains the standardized elements required for organizations to generate and report digital quality measure results.

A hierarchy is applied if quality data elements that support the numerator are identified in multiple data sources. Each SSoR used for HEDIS ECDS reporting is categorized using the following priority:

1. Electronic health record (EHR)/personal health record (PHR) (the system of data origin, such as laboratory, pharmacy, pathology, radiology).
2. Health information exchange (HIE)/clinical registry.
3. Case management system.
4. Administrative data.

Organizations compare the list of all unique systems containing relevant member data, and assign members based on the highest-ranked data category in the hierarchy. The applied hierarchy does not imply relevance or validity of a data source; rather, it is applied in cases where a member's data are in multiple locations.

Members are assigned to only one SSoR category for the numerator.

Organizations must complete data collection for SSoRs by the supplemental data collection deadline. Refer to *General Guideline: Audit Preparation* for information about the timeline.

When appropriate, an SSoR can be refreshed according to the organization's schedule and counted appropriately for the measure. Refer to *General Guideline: Obtaining Information for the Systematic Sample.*

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table SNS-E-: Metadata Elements for Social Need Screening and Intervention

Metric	Age	Data Element	Reporting Instructions
FoodScreening*	0-17	InitialPopulation	For each Metric and Stratification
FoodIntervention	18-64	Exclusions	For each Metric and Stratification
HousingScreening*	65+	Denominator	For each Metric and Stratification
HousingIntervention	Total	NumeratorByEHR	For each Metric and Stratification

	TransportationScreening* / ERegistry — NumeratorByCaseManagement — For each Metric and Stratification
Rules for Allowable Adjustments	***Copyright and use:*** The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent. **Adjusted HEDIS measures may not be used for HEDIS health plan reporting.** **ADJUSTMENTS ALLOWED** • *Product lines*. Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used. • *Ages.* The age determination dates may be changed (e.g., select, "age 60 as of June 30 of the measurement period"). • *Attribution.* Organizations are not required to use enrollment criteria. • *Benefits.* Organizations are not required to use a benefit. • *Other.* Organizations may use additional initial population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic. • *Exclusion.* Hospice, deceased persons, I-SNP and LTI exclusions are not required. • *Measurement period adjustments.* Organizations may adjust the measurement period. • *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events, numerators and exclusions that do not allow the use of telehealth. **ADJUSTMENTS NOT ALLOWED** • *Initial Population: Event.* Value sets, direct reference codes and logic may not be changed.

Social Needs Screening:
Literature Review on G and Z Codes

Background

Since their introduction in 2015, Z codes have become essential for capturing social determinants of health (SDOH), supporting a growing focus on health equity and reducing health care disparities.[1] To better document factors such as housing, food and transportation challenges, additional Z codes were introduced in 2021 and 2023, including Z59.02 (unsheltered homelessness), Z59.41 (food insecurity) and Z59.82 (transportation insecurity). These codes help health care providers track critical social factors affecting patient outcomes.[2]

To further support SDOH data collection, the Centers for Medicare & Medicaid Services (CMS) began requiring hospitals to screen inpatients for five key SDOH areas—food insecurity, housing insecurity, interpersonal safety, transportation insecurity, utilities—starting January 1, 2024. Along with this requirement, CMS introduced two SDOH-related quality measures and a new billing code, HCPCS G0136, which enables providers to bill for standardized SDOH risk assessment administration. These assessments, focused on social risk factors such as economic stability and the built environment, are critical for supporting accurate documentation and advancing health equity. Although Z codes are not yet fully integrated into risk-based payment models, they are used by CMS for health equity scoring—underscoring their growing importance. In consideration of the increased focus on Z codes and G codes for SDOH documentation in the industry, NCQA investigated literature related to these codes to inform their potential addition to accepted data elements for the *Social Need Screening and Intervention (SNS-E)* measure.

NCQA conducted a search of PubMed and EBSCO data bases. Search terms used included “Z codes,” “G codes,” “SDOH documentation,” “social determinants of health,” “medical coding for SDOH,” “health equity documentation” and “ICD-10 and social needs.” The search yielded 16 articles; 9 were determined relevant and are included in this literature review report. All the literature was published between 2017 and 2024. NCQA will continue to evaluate literature related to Z and G codes as the field evolves and the evidence-base grows.

Documentation and Utilization Patterns of Z and G Codes

Z codes have become essential for documenting SDOH in clinical settings, but utilization remains low. In Texas, documentation of SDOH Z-codes increased from 1% in 2016 to 1.3% in 2019 among Medicaid beneficiaries. Common categories include upbringing problems (37.8%), support group issues (23.4%) and education-related problems (15.9%).[3] In 2017, only 0.96% of Medicare fee-for-service (FFS) beneficiaries had documented Z-codes: predominantly younger, male, Black individuals living in low-income areas with higher medical complexity.[4] During ED visits from 2015–2019, Z-codes were recorded at a rate of 0.84%, with higher utilization in Maryland than in Florida, particularly among uninsured and Medicaid patients.[5] A study analyzing 2015–2018 EHR data from the OneFlorida Clinical Research Consortium found low use of ICD-10-CM Z codes for documenting SDOH.

At the encounter level, Z codes were recorded at a rate of 270.61 per 100,000 encounters, while at the patient level, only 2.03% of records included a documented Z code. Despite a slight increase following the 2018 guideline change allowing all clinicians to document Z codes, findings suggest the need for clearer guidelines, incentives and EHR improvements to enhance SDOH documentation.[6]

In a study of a Health Care for the Homeless Program from 2016–2022, only 28% of patients experiencing housing instability had a Z59 code, underscoring the limited use of these codes for capturing housing-related challenges.[7] A systematic review published in 2024 found that in mental health settings, Z-code documentation rates remained low, ranging from 0.5%–2.4% among publicly insured patients under 64 years of age with comorbidities, demonstrating variation based on demographics and hospital types.[8]

Most Frequently Used Z Codes

In 2021, CMS reported that Z-codes were largely underreported in Medicare FFS claims. By 2019, only 0.11% of claims for Parts A and B included Z codes, representing 1.59% of continuously enrolled beneficiaries.[9]

The most frequently reported Z codes in the Medicare population in 2019 were:

1. **Z59.0:** Homelessness.
2. **Z63.4:** Disappearance and death of a family member.
3. **Z60.2:** Problems related to living alone.
4. **Z59.3:** Problems related to living in a residential institution.
5. **Z63.0:** Problems in relationships with a spouse or partner.

Refer to the appendix for a full list of Z codes related to unmet food, housing and transportation.

Demographic Characteristics of Beneficiaries with Z Codes

Dually Eligible Beneficiaries: Those eligible for both Medicare and full-benefit Medicaid are overrepresented among Z code claims, indicating a higher likelihood of experiencing social and economic challenges.[9]

Rural Beneficiaries: Individuals residing in rural areas accounted for 39.7% of claims related to problems with living in a residential institution (Z59.3).[9]

Gender Distribution: Males represented 67.1% of claims for homelessness (Z59.0), despite making up only 45.4% of the overall FFS population.[9]

Racial Disparities: Black beneficiaries accounted for 24.8% of Z59.0 claims, while Hispanic beneficiaries comprised 9.2%, even though they constitute 8.8% and 5.9% of the total FFS population, respectively.[9]

Billing Patterns and Provider Types

Billing Patterns: Nearly half (49.6%) of Z codes were billed under Medicare Part B noninstitutional claims.[9]

Provider Types: The top providers billing Z codes in 2019 were:

1. Family practice physicians (15%).
2. Internal medicine physicians (14%).
3. Nurse practitioners (14%).
4. Psychiatry physicians (13%).
5. Licensed clinical social workers (12%).

SDOH-Related G Codes

Because G0136 is a new code (2024), research has not been done to understand its prevalence or utilization in documenting social needs. However, the appendix lists G codes that may be considered for use in capturing social needs data but requiring further testing.

Conclusion

The implementation of Z and G codes marks a significant advancement in capturing the SDOH that affect patient care and outcomes, but documentation and utilization remain low. Ongoing efforts by CMS to enhance SDOH data collection—through mandated screenings and standardized risk assessments—are crucial for advancing health equity and improving health care quality.

CMS requirements enhancing SDOH data collection through screening and assessment, integration of G codes into reimbursement policies and provider-level implementation efforts to facilitate further uptake of Z codes will all contribute to increased use. Increased use of Z codes will also improve data availability for reporting an updated version of the NCQA SNS-E measure.

Appendix A

Relevant Z and G Codes for the *Social Need Screening and Intervention* (SNS-E) Measure

ICD-10-CM Z Codes

- Z59.00—Homelessness unspecified
- Z59.01—Sheltered homelessness
- Z59.02—Unsheltered homelessness
- Z59.10—Inadequate housing, unspecified
- Z59.11—Inadequate housing environmental temperature
- Z59.12—Inadequate housing utilities
- Z59.19—Other inadequate housing
- Z59.41—Food insecurity
- Z59.48—Other specified lack of adequate food
- Z59.81—Housing instability, housed
- Z59.811—Housing instability, housed, with risk of homelessness
- Z59.812—Housing instability, housed, homelessness in past 12 months
- Z59.819—Housing instability, housed unspecified
- Z59.82—Transportation insecurity
- Z59.89—Other problems related to housing and economic circumstances

G Codes

- G0136—Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months
- G0019—Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s)
- G0023—Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities
- G0140—Principal illness navigation: Peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities
- G9919—Screening performed and positive and provision of recommendations
- G9920—Screening performed and negative
- G9921—No screening performed, partial screening performed or positive screen without recommendations and reason is not given or otherwise specified

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