

Improving Policy and Systems for Social Needs Measurement: Key Insights from First Year of National Health Plan Performance

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Background

Social determinants of health (SDOH), including food insecurity, housing instability or housing inadequacy, and inaccessible transportation, are non-clinical factors which are associated with worse overall health outcomes and access to care. SDOH have been recognized as important factors to consider in population health, as shown by the pursuit of SDOH-related Medicaid waivers among 21 states and reinforced by findings from a North Carolina pilot program that providing non-medical interventions led to lower monthly medical costs.¹ Health plans, medical providers, social service providers, and community-based organizations can help address these determinant to improve patient care and outcomes.^{2,3}

The National Committee for Quality Assurance (NCQA) developed a quality measure to capture health plan activity and performance in assessing and addressing the social needs of their member populations.

- Social Need Screening and Intervention (SNS-E):** % of persons who were screened using prespecified instruments, or assessed by a provider, for unmet food, housing, and transportation needs, and the percentage of persons with an identified need or positive screen who received a corresponding intervention. (published in HEDIS®⁴ for Measurement Year 2023, updated in HEDIS®⁴ for Measurement Year 2026)

Six indicators:

- Screening for Food Insecurity
- Screening for Housing Insecurity or Housing Inadequacy
- Screening for Transportation Insecurity
- Intervention for Food Insecurity
- Intervention for Housing Insecurity or Housing Inadequacy
- Intervention for Transportation Insecurity

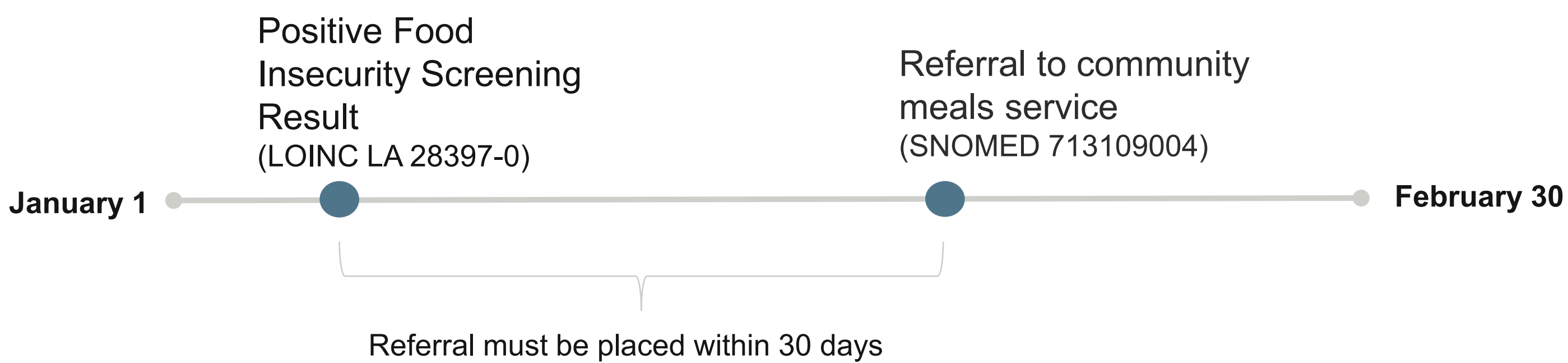
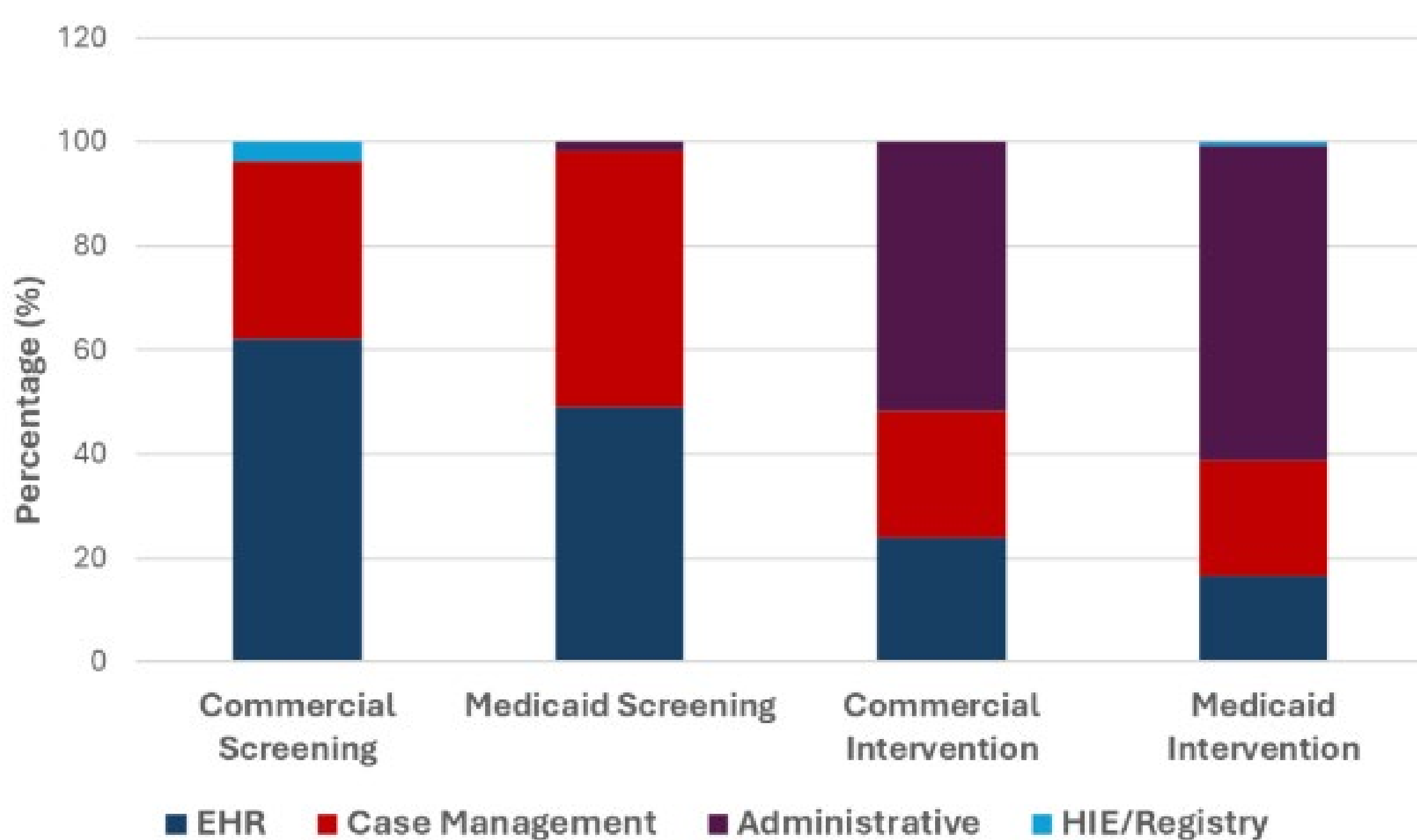


Figure 1. Example of Food Insecurity Indicator within the Social Needs Screening and Intervention (SNS-E) Measure

Data and Methods

- Retrospective analysis of health plan performance on SNS-E from HEDIS Measurement Year 2023 (Jan 1 – Dec 31, 2023)
- 501 health plan contract submissions that reported valid (audited) rates were included in the analysis:
 - Medicaid (n = 184 contracts)
 - Commercial (n = 317 contracts)
- Health plan size (total enrollment):
 - Medicaid: 1,000 - 2 million members
 - Commercial: 400 - 2.5 million members
- Accepted data sources for reporting include:
 - Electronic Health Records (EHRs)
 - Case Management systems
 - Administrative Data (e.g. claims)
 - Health Information Exchange (HIE) / registries.
- Health plan ability to report rates weighted by enrollment size to account for variation in health plan size.

Figure 2. Percent of Numerator Hits from Each Data Source by Product Line



Reporting and Performance Results

Health plans were considered able to report if they were able to identify at least 30 individuals for the indicator denominator. Broadly:

- ~ 70% of plans were able to report screening indicators
- <10% of plans were able to report intervention indicators.

When a health plan has a large enough population to be measured, but no individuals met the criteria for the measure, rate of zero is reported to NCQA.

- Majority of plans reported rates of zero.
- Among plans that reported a rate above zero, average screening rates remaining under 1% across product lines.

Table 1. Weighted Average Reporting Rate Across Product Lines

Domain	Indicator	Percent of Submissions with Reportable Performance Rates*		
		Commercial	Medicaid	Both Product Types
Food	Screening	75.5	66.2	70.9
	Intervention	6.0	9.0	7.5
Housing	Screening	75.5	66.2	70.9
	Intervention	4.8	10.1	7.5
Transportation	Screening	75.5	66.2	70.9
	Intervention	3.8	7.9	5.9

Percentage of Plans with Rates of Zero:

- Food Screening:
 - 57% of Commercial Plans (n=182)
 - 69% of Medicaid Plans (n=127)
- Food Intervention:
 - 20% of Commercial Plans (n=5)
 - 4% of Medicaid Plans (n=1)

*Similar rates were observed for housing and transportation.

Across both screening and intervention indicators, product lines, and age groups, performance reveals considerable variation and significant opportunities for improvement. When focused solely on overall screening for any social need domain:

- Commercial plans have slightly higher average screening rates (0.4%) compared to Medicaid (0.3%) plans.
- Performance rates amongst intervention indicators were much higher than performance rates for screening indicators given the vast reduction in the sample size.
- Screen positive rates were highest in Medicaid (42.2%), followed by commercial (26.6%).

Table 2. Average Performance Rates in 2023 by SDOH Domain, across all age groups, for the SNS-E measure

Product Line	SDOH Domain	Screening Rate*	Positive Screen ^v (calculated)	Intervention Rate**
Commercial	Food	0.4	22.3	18.3
	Housing	0.4	29.8	16.7
	Transportation	0.4	27.6	21.7
	Average %***	0.4	26.6	18.9
Medicaid	Food	0.3	46.4	24.6
	Housing	0.4	39.5	19.3
	Transportation	0.2	40.8	25.1
	Average %***	0.3	42.2	23.0

* Percentage of members who were screened, using a prespecified instrument, at least once during the measurement period for unmet food, housing or transportation needs.

^v The positive screen rate is calculated as percentage of members who screened positive on a prespecified instrument, of all members who received an initial social need screen.

** The percentage of members who received a corresponding intervention within 30 days, if they screened positive.

*** Average percentage across food, housing and transportation SDOH domains.

Conclusion

National health plan performance on the NCQA *Social Needs Screening and Intervention* measure shows that Commercial plans were able to report screenings on all three social need domains more than Medicaid plans. However, Medicaid plans were more able to report intervention indicators than Commercial plans. The overall difficulty reporting the measure highlights the need for wider adoption of social needs screenings and stronger data exchange systems. Standardized data elements and improved interoperability are critical to tracking social needs over time, supporting care continuity, and driving measurable population health improvements.

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Implications for Policy

Federal Supports



- Recent policy actions, including CMS rescinding guidance related to social needs, creating uncertainty around federal support for state actions.⁵
- Performance data shows screenings are low or under-reported, which prevents payers (private and public) from evaluating true level of unmet need.
- Challenges for efficient resource distribution and closing gaps in the absence of federal guidance/supports and low screening rates.

Health Information System Interoperability



- First-year SNS-E data revealed significant limitations in data transfer from HIEs to health plans. Centralizing data in **Health Information Exchanges (HIEs)** can improve reportability of SNS-E.
- HIEs support aggregation and dissemination of electronic clinical data and support modernizing our health information systems and enhancing care coordination.
- State and federal policy facilitating and incentivizing system interoperability will enable more effective measurement and response to community-level social needs.

Screening Standardization & Payment Across States



- The SNS-E measure could act as a useful tool for facilitating alignment across states given the current fragmented Medicaid SDOH screening landscape.
- Roughly 50% of states include SDOH screening language in Medicaid MCO contracts; 75% of Medicaid plans utilize performance measures to assess SDOH initiatives.⁶
- Use of **standardized screening questions** across states, and alignment with the evidence-based tools included in SNS-E, would help facilitate comparison across states and identification of quality gaps.