MEDICAID FOOD SECURITY NETWORK

Medicaid Food Security Network response to: "Request for Information: Administration for Children and Families Development of Interoperability Standards for Human Service Programs"

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The Medicaid Food Security Network is a group of healthcare and food security stakeholders convened by Share Our Strength and HealthBegins. MFSN mobilizes Medicaid systems to become a key partner in addressing food and nutrition insecurity. Participants in MFSN engage, influence, and partner with state Medicaid programs and Medicaid-serving systems (Managed Care Organizations and providers) to adopt and implement effective strategies to support the food needs of children and families enrolled in Medicaid, with an emphasis on closing the enrollment gap in the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

The Medicaid Food Security Network supports the Administration for Children and Families' efforts to pursue interoperability standards for human services programs grounded in partnerships with ASTP and ONC, and the Gravity Project, with incorporation of USCDI and FHIR/HL7 standards. **Our comment focuses on improving and expanding interoperable data-sharing to enhance the ability of the healthcare sector to access SNAP and WIC data to better serve Medicaid enrollees.** Medicaid, SNAP, and WIC have overlapping eligibility requirements and stable federal funding, yet there are significant participation gaps in SNAP and WIC enrollment. Around 1 in 5 people who are eligible for SNAP are not enrolled.[1] Half of people eligible for WIC are not enrolled, with the lowest enrollment rates among children aged 2 to 5.[2] In the case of WIC, adjunctive eligibility means that individuals enrolled in SNAP or Medicaid are automatically eligible for WIC if they meet the demographic criteria for the program (i.e., pregnant, postpartum, and/or children under 5). There remain many barriers to enrolling relating to awareness, technology, transportation, and perceived stigma.

There is increasing recognition among healthcare systems that SNAP and WIC enrollment are a foundational part of addressing food insecurity, improving health outcomes, and reducing avoidable healthcare costs. An analysis of adult Medicaid participants found that SNAP enrollment was linked to healthcare savings of $1,409 per year.[3] WIC is associated with lower preterm birth and infant mortality.[4] Medicaid policy flexibilities to pay for social needs have increased, and many state Medicaid systems require health-related social needs (HRSN) screening and resource connections for participants.[5] For healthcare systems to support enrollment in SNAP and WIC as part of their HRSN strategies, they require access to data to do the same quality improvement and closed loop referral systems, as they do with any other referral necessary for a clinical care plan.

SNAP and WIC data-sharing to healthcare organizations already occurs or is planned to go into effect in several states. However, there remains a lack of clarity around the legal authority and perceived risks of this type of data sharing. Therefore, **there is a need for enhanced unified federal guidance and leadership to scale up cooperation and collaboration across agencies that host these programs to support enrollment and participation in SNAP, WIC, and other food security programs.**

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[1] https://www.fns.usda.gov/research/snap/participation-rates-2020
[2] https://www.fns.usda.gov/research/wic/eligibility-and-program-reach-estimates-2020
[3] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653910
[4] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2756257
[5] https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2024-2025-executive-summary/

Key use cases for SNAP and WIC data-sharing to healthcare

Several primary use cases for sharing SNAP and WIC data with healthcare are:

1. Enable better targeting of outreach to people who are likely eligible but not enrolled in SNAP or WIC both in non-clinical and nonclinical settings. This may include:
    a. A clinic-based community health worker has a pregnant patient with a positive food insecurity screening, so the CHW uses their closed-loop referral tool to connect them to food resources. Within the referral tool, the CHW is also able to check efficiently if the patient is currently enrolled in SNAP and WIC. Then, the CHW assists the patient in filling out a SNAP application and making an appointment with their local WIC clinic.
    b. A Medicaid managed care organization would like to send text messages to members encouraging them to apply for SNAP. Therefore, they match their list of Medicaid members with a state database (through an API connection) to identify which members are currently enrolled in SNAP or not. Messages are then targeted only to members not currently enrolled in SNAP.
2. Streamline the ability for healthcare teams to follow up on SNAP and WIC enrollment outcomes, to enable quality and process improvement (as opposed to "manual" follow-up through phone calls or conversations during subsequent encounters).
3. Enable high-quality evaluation of benefits access interventions, sustaining the business case for investments and rigorous health outcome studies to build upon existing evidence that SNAP is associated with reduced healthcare costs and avoidable healthcare utilization.

Precedents for SNAP and WIC data-sharing to healthcare

SNAP and WIC data-sharing to healthcare organizations such as MCOs have expanded in recent years, and we name a couple of examples here:

- In 2021, the Pennsylvania Department of Human Services (PA DHS) began to share individual-level SNAP participation data with all Medicaid Managed Care Organizations (MCOs) in the state so that MCOs would have better insight into whether each of their members is enrolled in a critical public benefit. Through this arrangement, PA DHS shares SNAP enrollment information on the "834 Enrollment Files."[6] These are files sent by the PA DHS Medicaid agency to its MCOs to identify Medicaid participants who are enrolled with that MCO. Since 2021, these files, sent to the MCOs monthly, have been enriched with data elements describing Medicaid SNAP enrollment and related dates. The specific data elements are: Medicaid enrollee's date of starting SNAP participation, end date of SNAP certification period, SNAP renewal deadline, and SNAP semiannual reporting deadline. Visibility on these dates enable MCOs to conduct outreach that supports SNAP renewal for currently enrolled members, in addition to outreach and application support for those not enrolled.
- California's Data Exchange Framework Roadmap, whose implementation began in 2024, includes a data-sharing agreement that enables partner agencies to share individual-level eligibility and enrollment data across WIC, SNAP, and Medicaid.[7] California Department of Health Care Services (DHCS) will support managed care organizations to create lists of Medicaid members likely eligible but not enrolled in SNAP and WIC. MCOs will then use these lists to conduct outreach and application support.

[6] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/for-providers/documents/promise-companion-guides/c_216078.pdf
[7] https://www.cdii.ca.gov/wp-content/uploads/2024/11/CalHHS_DxF_Roadmap_Draft-for-Public-Comment_11.7.24_Updated.pdf

Enablers and barriers to data-sharing

A need for further federal guidance on SNAP and WIC data-sharing

The USDA released key guidance on WIC data-sharing in 2023, which articulates use cases for WIC data-sharing to third parties including healthcare.[8] An enabler to the creation of this guidance was the 1992 Medicaid-WIC regulation (42 CFR § 431.635) that requires coordinating operations, referrals, and outreach to Medicaid enrollees to inform them about WIC.[9] This coordination regulation ensures that every state Medicaid MCO contract requires WIC coordination and provides necessary encouragement to states. However, there remain practical implementation questions, with state benefit agencies and healthcare stakeholders navigating whether additional consent collection is necessary to enable the data-sharing described.

However, there is no analogous federal regulation explicitly requiring Medicaid and SNAP coordination. In addition, guidance similar to the 2023 USDA WIC guidance does not exist for SNAP data-sharing. The creation of a new regulation requiring the coordination and/or integration of these two critical safety net programs would create clearer lines of accountability that would support the rationale for data sharing.

Despite the legal rationale and existing precedents, some state officials find it difficult to engage in data sharing without clearer federal cross-agency guidance around the practice. In 2022, the Center for Health Care Strategies and Benefits Data Trust conducted a 50-state survey of SNAP and Medicaid agencies. Respondents from 83 percent of states (39 of 47 responding) reported that they would like more federal guidance to help facilitate data-sharing.[10]

To advance progress on public benefit data-sharing, we **recommend that HHS collaborate with the US Department of Agriculture (USDA) to create additional unified guidance to facilitate SNAP and WIC data-sharing between state agencies and with healthcare organizations.** Such guidance should include:

- A model template for data sharing agreements that has been vetted by both HHS and USDA;
- Examples of states and healthcare organizations that are engaged in innovative data-sharing projects;
- A description of what data can be shared, with whom, and under what circumstances;
- A description of when consent or additional consent collection is needed for data-sharing and when it is not;
- Strategies to reconcile operational and structural differences in data structure to harmonize them across programs and with FHIR standards; for example, how households are identified and tracked. SNAP, WIC, and Medicaid each have their own ways of defining households. Meanwhile, most healthcare data in electronic health records is stored at the individual-level, which means that tracking SNAP or WIC participation across two patients in the same family or household may be a challenge.

Such guidance should be responsive to the needs of Medicaid managed care organizations and other health plans, hospital systems, outpatient clinical settings, and community organizations - all of whom can conduct more efficient operations when there is joint visibility of SNAP and WIC enrollment status. Guidance alone is necessary but not sufficient, as there also needs to be additional government and philanthropic investment in funding and technical assistance for all stakeholders, particularly community organizations, to develop HIPAA-compliant data sharing and management systems.

Related to the need for data sharing guidance is a **need for clarity about how outreach funds for SNAP, WIC, and Medicaid can be blended and braided**. While this comment does not go into detail on this, given that outreach and enrollment are a core purpose of data sharing, federal data sharing guidance may be most impactful when paired with guidance on blending and braiding outreach funding streams.

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[8] https://www.fns.usda.gov/wic/data-sharing
[9] See CFR 431.635.
[10] Data Coordination at SNAP and Medicaid Agencies: A National Landscape Analysis (January 2023) (A collaboration between BDT and the Center for Health Care Strategies) - Unpublished result from the 50-state survey.

Risks of data-sharing

On top of the well-recognized importance of data privacy and compliance with all relevant privacy laws, we additionally wanted to highlight that data-sharing must never facilitate the disclosure of household member immigration status to agencies that enforce immigration. This is of particular concern for WIC and emergency Medicaid, which are available regardless of immigration status. SNAP is also available to households of mixed immigrant status, typically when children have US citizenship. Immigration enforcement triggered by public benefit participation would not only negatively impact the health of families directly affected, but also cause hesitation to participate among other eligible immigrants. This "chilling effect" on SNAP and WIC participation occurred when the presidential administration considered adding SNAP to the "Public Charge" Inadmissibility Rule in 2019. Even though this rule was not implemented after legal disputes, there were reported reductions in SNAP and WIC participation and concerns among immigrant populations about participating in public benefits.[11]

Next steps

In conclusion, the Medicaid Food Security Network would be excited to discuss with ACF and other relevant stakeholders to support efforts to facilitate successful interoperability and secure sharing of public benefits participation data to support better integration among the healthcare, government, and HRSN spaces. If you have questions about this comment and its recommendations, please feel free to contact us.

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[11] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/ and https://www.kff.org/racial-equity-and-health-policy/issue-brief/2022-changes-to-the-public-charge-inadmissibility-rule-and-the-implications-for-health-care/