NCQA Standards and Measures to Address the Social Drivers of Health

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NCQA'S IMPACT

203 Million People

are covered by health plans that report HEDIS

73% of Americans

with health insurance are covered by an NCQA-Accredited plan

60,000+ Clinicians

work in an NCQA-Recognized medical practice

13,000+ Entities

are Accredited, Certified or Recognized by NCQA

NCQA's MISSION *Improve the quality of health care*

NCQA

NCQA invests in health equity in more ways than one

RESEARCH & PARTNERSHIPS

Tools for sustainable partnerships between health care and communities

Accuracy, completeness and exchange of equity data collected by health sector stakeholders

Supporting equitable outcomes in key populations such as birth equity

Advancing approaches for health equity accountability through measurement and scoring

High-impact federal partner providing research and policy services.

Focusing on collaboration with community

MEASUREMENT & DATA

- **Stratifying HEDIS measures** by race/ethnicity
- **Measures of social needs** screening and intervention
- **Making HEDIS more inclusive** of gender identity
- **Advance equity for individuals with disabilities** through community-centered approaches.
- **Digitalization of HEDIS®** measures allows for greater and more flexible measure configurations that can support insights into sub-populations.
- **Align with data standards**, including USCDI, CARIN for Blue Button®, the Gravity Project and the Gender Harmony project.

PROGRAMS

Health Equity Accreditation

Health Equity Accreditation Plus

Embedding health equity in other programs
(e.g., LTSS Accreditation, Health Plan Accreditation, PCMH Recognition)

BRIDGING INSIGHTS

NCQA's Health Equity Accreditation Plus

Collection, Acquisition and Analysis of Community and Individual Data

Cross-Sector Partnerships and Engagement

Data Management and Interoperability

Program to Improve Social Risks and Address Social Need

Referrals, Outcomes and Impact

NCQA's Health Equity Accreditation Plus

Collection, Acquisition and Analysis of Community and Individual Data Standards

- ✓ Define Community
- ✓ Acquire Population Social Risk Data
- ✓ Collect Social Needs Data Directly
- ✓ Identify Disparities/Differences
- ✓ Conduct Risk Stratification or Population Segmentation
- ✓ Identify Priority Social Risks and Needs

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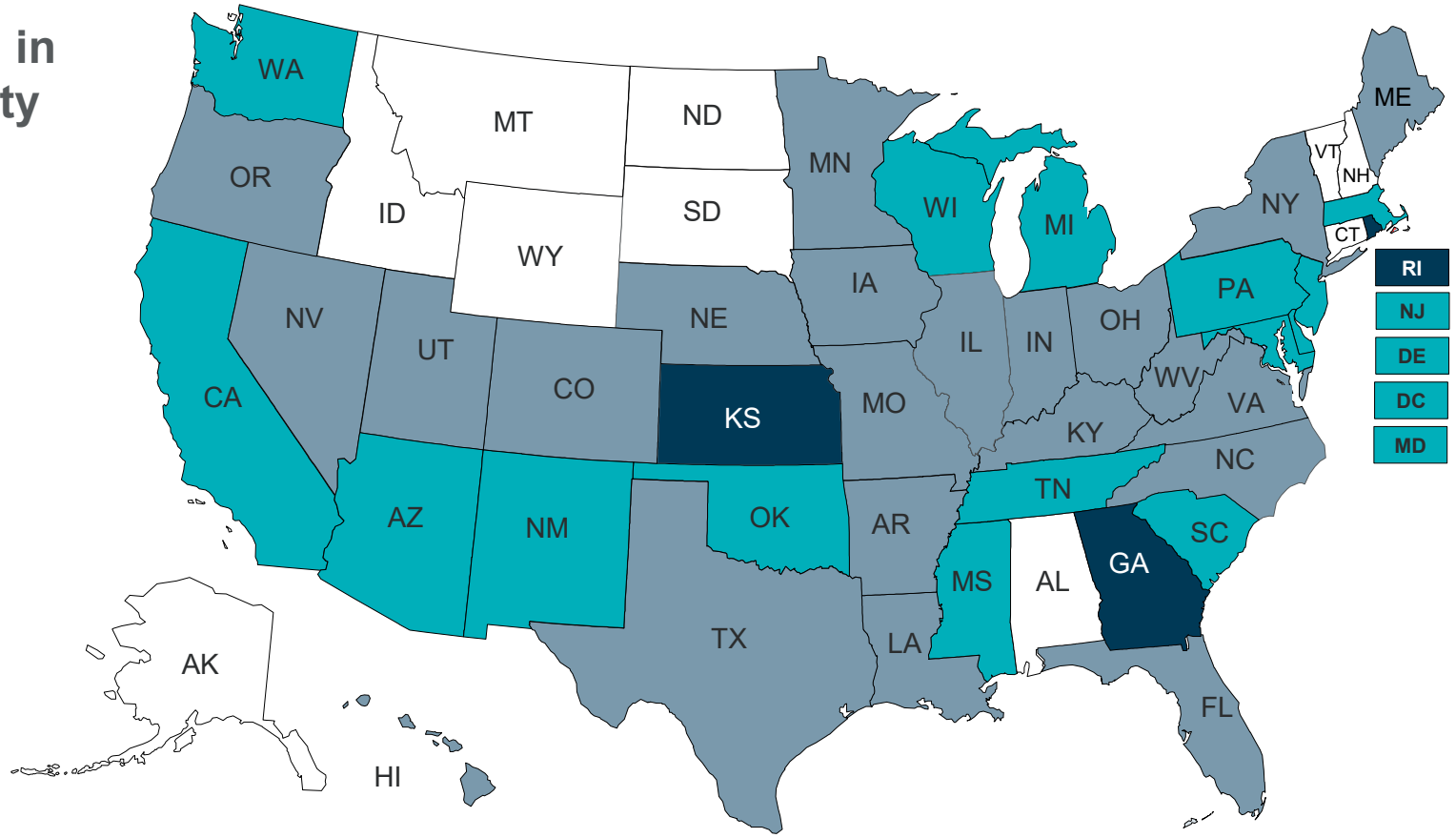
Six required domains: food, housing, transportation, financial insecurity, interpersonal safety, and any other sixth domain

Framework for direct collection of social needs (details of collection methods)

Internally developed or standard external screening tools allowed

Health Equity Accreditation is becoming *the* foundation for states to build on

36M+ covered lives in NCQA Health Equity Accreditation



Required to Achieve NCQA's Health Equity Accreditation (16 States + D.C)

Required to Achieve NCQA's Health Equity Accreditation Plus (3 States)

States with voluntary adoption of HEA (formerly Multicultural Health Care Distinction) by plans serving one or more populations (Medicaid, Exchange, Medicare or Commercial).

NCQA

HEDIS® creates accountability for social needs & interventions

HEDIS SDOH measures:

- **Social Need Screening & Intervention** *(MY 2023)*
- **Intimate Partner Violence** *(under development for MY 2027)*
- **Utility Insecurity** *(under development)*
- **Social Connection** *(under development)*

ACCREDITED NCQA HEALTH EQUITY PLUS

gravity PROJECT

SDOH Domains

TRANSPORTATION INSECURITY	HOUSING INSTABILITY
FOOD INSECURITY	INTIMATE PARTNER VIOLENCE

Measure Specification

Social Need Screening and Intervention (SNS-E) for MY2023

Measure Description

The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using a pre-specified screening instrument and, if screened positive, received a corresponding intervention.

Six Indicators:

1. Food Insecurity Screening
2. Food Insecurity Intervention
3. Housing Screening
4. Housing Intervention
5. Transportation Insecurity Screening
6. Transportation Insecurity Intervention

Product Lines

Commercial, Medicaid, Medicare

Reporting Method

Electronic Clinical Data Systems

Exclusions

Hospice

I-SNP

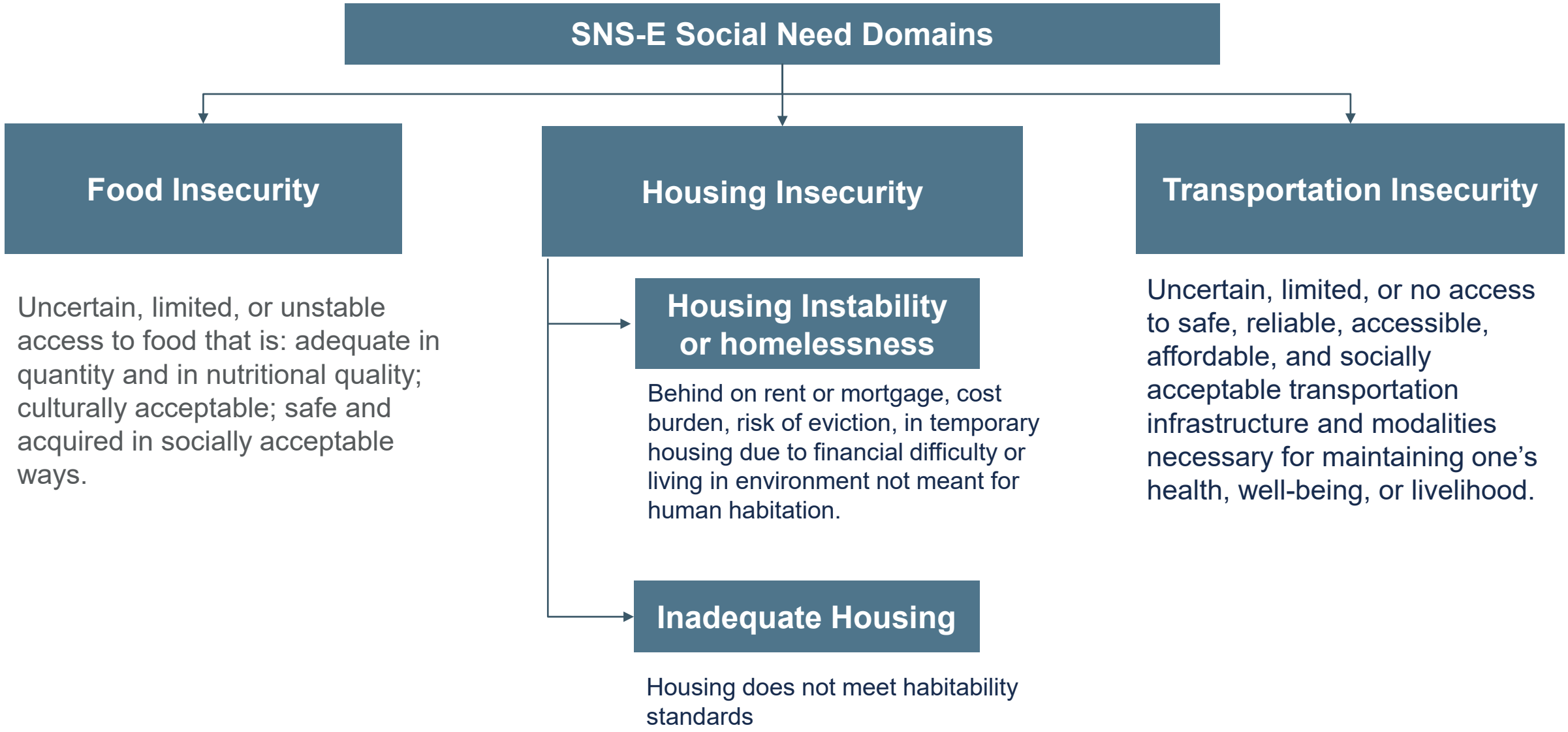
LTI

Age Stratification

- ≤17
- 18-64
- 65+

Social Need Domains

Three domains of focus



Social Need Domains

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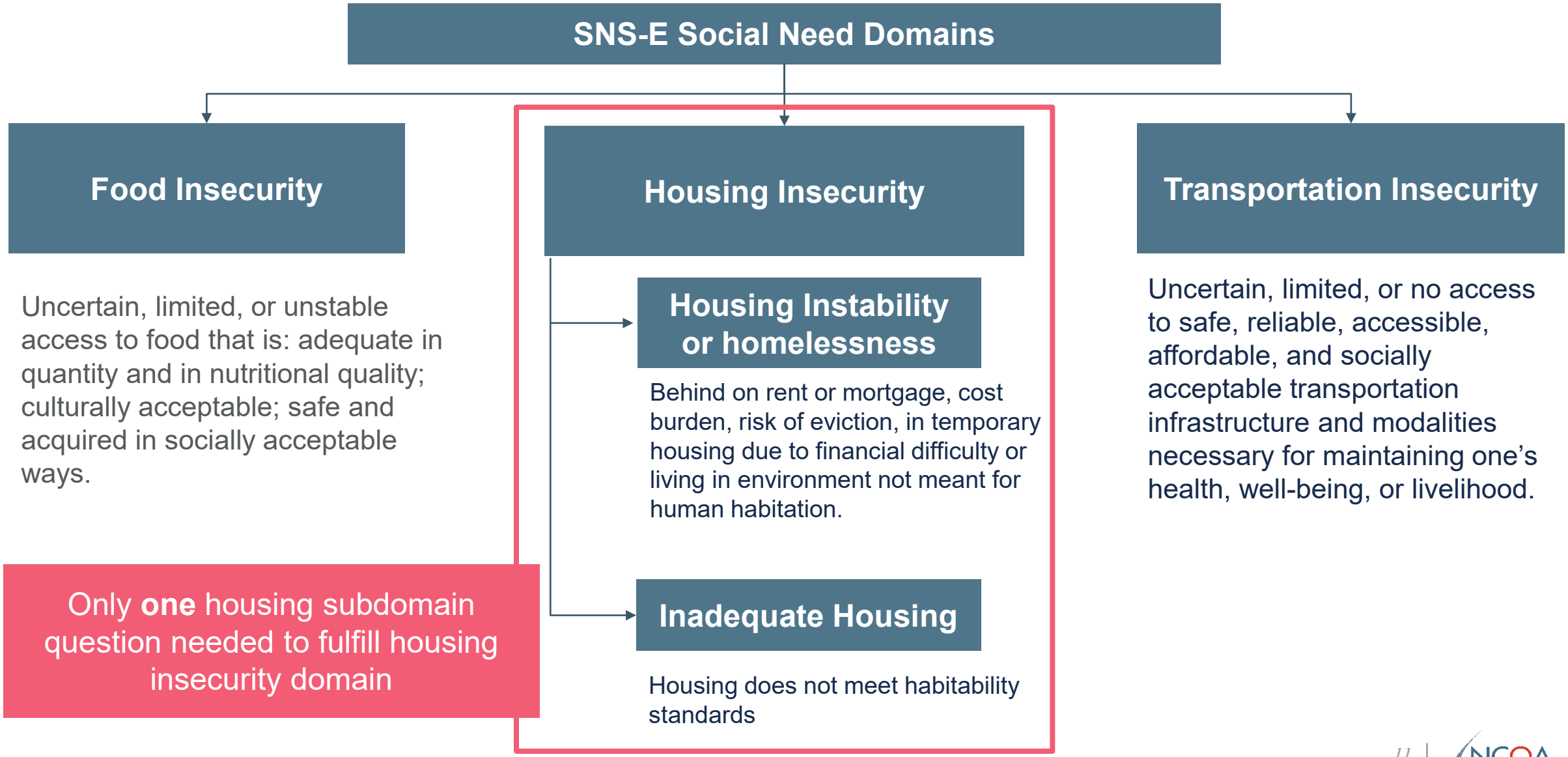


Measure Specification

Indicator Breakdown

Screening

Numerator: Members with 1+ documented result on screening (LOINC)

Denominator: Members continuously enrolled during MY

Intervention

Numerator: Members with intervention within 30 days of positive screen (CPT, SNOMED)

Denominator: Members with at least 1+ positive screening result (positive LOINC)

Screening Example

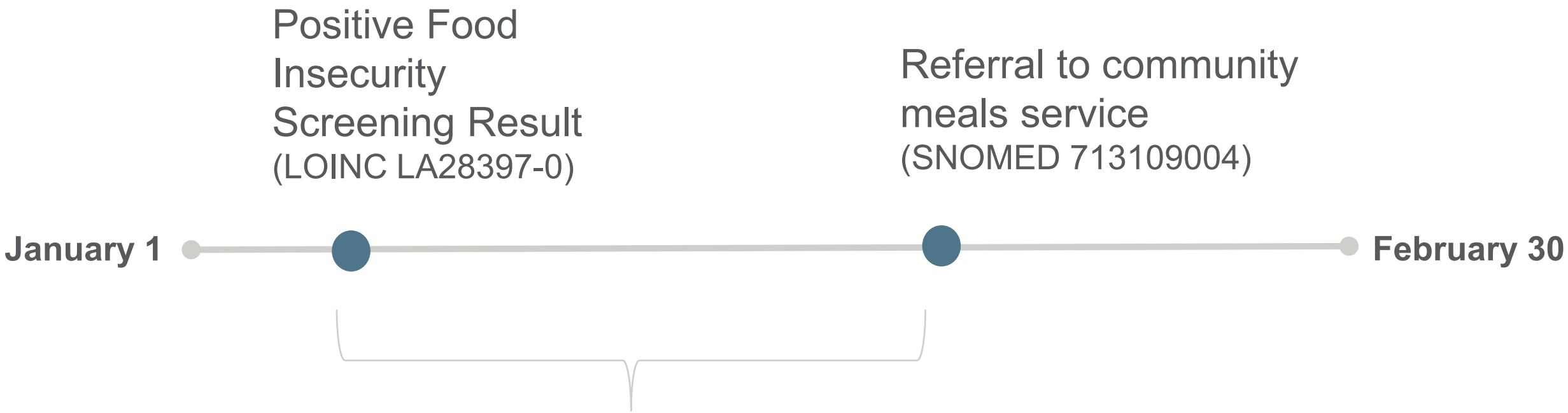
Cultural and linguistic adaptations to standard screening tools allowed.

Social Need Screening Questionnaire

Hunger Vital Sign *Food*	1. Within the past 12 months, you worried that your food would run out before you got money to buy more. (88122-7)	❑ **Often True (LA28397-0)** ❑ **Sometimes True (LA6729-3)** ❑ Never True (LA28398-8)	Positive
PRAPARE *Housing*	2. Are you worried about losing your housing? (93033-9)	❑ **Yes (LA33-6)** ❑ No (LA32-8)	Positive
Health Leads *Transportation*	3. In the last 12 months, have you ever had to go without healthcare because you didn't have a way to get there? (99553-0)	❑ **Yes (LA33-6)** ❑ No (LA32-8)	Positive

Intervention Documentation Example

Food insecurity



Examples of Interventions

Defined in Gravity Project Value Sets

Intervention type	Example
Assistance	Assistance with application to Homelessness Prevention program
Assessment	Assessment of barriers in inadequate housing care plan
Coordination	Coordination of care plan
Counseling	Counseling for readiness to implement food insecurity care plan
Education	Education about area agency on aging program
Evaluation	Evaluation of eligibility for a fuel voucher program
Referral	Referral to area agency on aging
Provision	Provision of home-delivered meals

Captured via CPT, SNOMED, HCPCS codes

First Year Analysis

MY 2023 Data Analyzed in August 2024

Health Plan Ability to Report

Indicator Performance Rates

Data Sources

Public Reporting?

First Year Analysis

High Level Findings	*Implications*
Performance demonstrates significant variation and room for improvement.	The measure is meaningful and helpful for comparison between health plans.

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Large portion of plans reporting rates of zero for screening indicators, many plans unable to report intervention indicators due to small denominator sizes.	Improvements to SDOH documentation and data mapping systems will facilitate reporting in future years.

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Administrative code sources highly used for reporting interventions.	Health plans will make use of administrative billing codes where our measure accepts them.

Charting New Territory

Qualitative Interviews from Health Plans Collecting SDOH Data

Table 1. Summary of health plan code availability.

	Code type		
	Logical Observation Identifiers, Names, and Codes (LOINC) (for screenings)	Systematized Nomenclature of Medicine (SNOMED) (for interventions)	ICD-10 Diagnosis Codes to capture social determinants of health (Z codes) (for screenings or interventions)
Social connection interviews			
Health plan A	Yes	Yes	Yes
Health plan B	No	Yes	Yes
Health plan C	No	Yes, but difficult	Yes
Utility insecurity interviews			
Health plan D	Yes, implemented	Unknown	No
Health plan E	Yes, ability to pull	Yes, ability to pull	Yes, main source
Health plan F	No	Yes, can request	Currently implementing
Health plan G	No	No	Yes, manually mapped
Health plan H	No, manual mapping required	Yes	Yes

(Nava, Bishop, Lissin, Harrington, 2024)

Policies and Interactions Advancing SDOH Data Collection

Opportunities for Alignment

Office of the National Coordinator for Health Information Technology

gravity PROJECT

LOINC® from Regenstrief

Z codes are a subcategory of the International Classification of Diseases, Clinical Modification (ICD-CM) system.

Medicare

Medicaid

Data Standards

- ONC expanded USCDI by moving from v1 to v3 by January 1, 2026; requires the adoption of the HL7 FHIR US Core IG
- Mandated USCDI SDOH elements: assessments, problems, interventions and goals; alignment with Gravity Project value sets

Data Collection

- 2024 Physician Fee Schedule- new G code for screening
- At least 28 states recommend SDOH screening; 17 require uniform questions
- Anticipate Hospital eCQM to contain Z codes

Payment and Policy

- Medicare Advantage (MA)- Special Supplemental Benefits; and SNP requirements
- Medicaid and CHIP Managed Care Regulations
- Medicaid Section 1115 Waivers

Next Steps for Expanding Data Terminology

Social Need Screening and Intervention Measure MY2026

1. Evaluate the addition of G and Z administrative codes
2. Implement appropriate measure updates
3. Consider measure for public reporting for MY2027+
4. Consider additional domains for MY2027+

SNS-E Updated Code List

Proposed Code Additions and Removals

G0136: Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months

Add to Screening Numerator
Updated in 2024 Physician Fee Schedule

Z59 codes related to housing (homelessness, housing insecurity, and housing inadequacy), food, and transportation.

Add to Intervention Denominator
Updated in 2021, 2022 to ICD-10 coding

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, G0140: Principal illness navigation services

Add to Intervention Numerator
Updated in 2024 Physician Fee Schedule

CPT 96161, 96160,96156: Administration of health risk assessment or health behavior assessment

Remove from Intervention Numerator

Measure Specification

Social Need Screening and Intervention (SNS-E)

Measure Description

The updated SNS-E measure assesses 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, and the percentage of persons with an identified need or positive screen who received a corresponding intervention.

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LOINC OR G0136

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CPT, SNOMED

+ Service G codes

− Assessment CPT codes

LOINC OR Z Code

Critical Opportunity: SDOH Measure Alignment

(Abrams, Nuzum, Chang, Perla, 2023)

	Five Core Domains in CMS's DOH Operational Definition					
Program/Initiative/Guidance	**Food Insecurity**	**Housing Instability**	**Transportation Needs**	**Utility Difficulties**	**Interpersonal Safety**	**Responsible Entity**
Federal						
Hospital Inpatient Quality Reporting Program	X	X	X	X	X	CMS/CCSQ
Merit-based Incentive Payment System	X	X	X	X	X	CMS/CCSQ
End-Stage Renal Disease Quality Incentive Program [1]	X	X	X	X	X	CMS/CCSQ
PPS-exempt Cancer Hospital Quality Reporting Program[1]	X	X	X	X	X	CMS/CCSQ
Inpatient Psychiatric Facility Prospective Payment System[1]	X	X	X	X	X	CMS/CCSQ
ACO REACH model	X	X	X	X	X	CMS/CMMI
Value-Based Insurance Design model	X	X	X	-	-	CMS/CMMI
2024 MA Part C/D rate notice (SNS-E)	X	X	X	-	-	CMS/CMMI
Supplemental benefits[2]	X	-	X	-	-	CMS/CM
Special supplemental benefits for chronically ill[3]	X	X	X	X		CMS/CM
Physician fee schedule	-	-	-	-	-	CMS/CM
Star Ratings measures (MA)	-	-	-	-	-	CMS/CM
Healthy People 2030 goals	X	X	-	-	-	HHS/ODPHP
USCDI standards v4	X	X	X	-	X	HHS/ONC
ONC SDOH Information Exchange Toolkit (Healthy People 2030)	X	X	-	-	-	HHS/ONC
Billable SDOH ICD-10 Z-codes	X	X	X	X	X	CMS/CDC
HHS risk adjustment model coefficients	-	-	-	-	-	CMS/CCIIO
NQF risk adjustment guidance on social & functional risk factors[4]	-	-	-	-	-	CMS
State/Medicaid						
Medicaid core measure set	-	-	-	-	-	CMS
California: In Lieu Of Services (ILOS)	X	X	X	X	-	State
Arizona: Section 1115 Waiver Demonstration	-	X	-	X	-	State
Massachusetts: Section 1115 Waiver Demonstration	X	X	X	-	-	State
New Jersey: Section 1115 Waiver Demonstration	X	X	-	-	-	State
Oregon: Section 1115 Waiver Demonstration	X	X	-	-	-	State
North Carolina: Section 1115 Waiver Demonstration	X	X	X	X	X	State
Private sector						
HEDIS SDOH measures	X	X	X	-	-	NCQA

[1]proposed; [2]time-limited; [3]specific subset of population; [4]guidance is general/conceptual and it is unclear which specific domains are included

NCQA

Thank you