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Child and Adult Core Sets Annual Review Workgroup:

Measures Suggested for Removal from or Addition to the 2026 Core Sets

Measure Information Sheets

February 2024

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR REMOVAL FROM THE 2026 CORE SETS

Measure Information	
Measure name	**Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)**
Description	The percentage of beneficiaries aged 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.
Measure steward	Pharmacy Quality Alliance (PQA)
Core Set	Adult Core Set
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
If measure is removed, does it leave a gap in the Core Set?	The Workgroup member (WGM) who suggested the measure for removal stated that removing it would not leave a gap because the existing *Use of Pharmacotherapy for Opioid Use Disorder* measure addresses treatment for opioid use disorder in the Adult Core Set. However, during prior Workgroup discussions, some Workgroup members suggested removal of this measure would leave a gap. For example, at the 2021 Core Set Annual Review Meeting, one Workgroup member noted that this is the only Core Set measure that makes prescribers and pharmacies accountable for overprescribing, over dispensing, and overuse of opioids.[1]
Has another measure been proposed for substitution (new or existing measure)?	No
Is there another related measure in the Core Set?	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Meaningful Measures area	Behavioral Health
Use in other CMS programs	• Medicare Shared Savings Program • Included in CMS's Medicare Part D quality program and publicly reported as a Display Measure

FFY 2024 Technical Specifications	
Ages	Age 18 and older as of January 1 of the measurement year.
Data collection method	Administrative.

Denominator	Beneficiaries who meet all the following criteria: 1. Two or more prescription claims for opioids medications on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. 2. An Index Prescription Start Date (IPSD) on January 1 through October 3 of the measurement year. 3. An opioid episode of 90 or more days during the measurement year. Notes: • Exclude days' supply that occur after the end of the measurement year. • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.
Numerator	Any beneficiary in the denominator with an average daily dosage ≥ 90 morphine milligram equivalent (MME) during the opioid episode.
Exclusions	Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice. • Cancer Diagnosis. • Sickle Cell Disease Diagnosis. • Palliative Care. The exclusion criteria are for beneficiaries with claims for the relevant conditions during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
Continuous enrollment period	The measurement year with one allowable gap, as defined below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).

Reasons for Removal Noted by Workgroup Member(s)

Minimum Technical Feasibility Criteria

None identified by the WGM.

Actionability and Strategic Priority

The WGM stated their opinion that this measure does not address a strategic priority for improving health care delivery and outcomes because it does not focus on the unique and complex needs of Medicaid beneficiaries.[a] More specifically, the WGM highlighted that the measure conflicts with Goal 3 of the CMS Behavioral Health Strategy[2] and two of its objectives:

> Goal 3: Ensure effective pain treatment and management.
>
> - Improve the care experience for individuals with acute and chronic pain to identify strategic opportunities for enhanced access to high quality, equitable, affordable whole-person care.
> - Expand access to evidence-based treatments for acute and chronic pain, including through guidance to states, exploration of new coverage pathways, and sharing practices that ensure individualized, effective care.

Furthermore, the WGM noted that the *2022 Clinical Practice Guideline for Prescribing Opioids for Pain*[3] was developed using the best available scientific evidence published since the release of the 2016 guideline, with input from subject matter experts, clinicians, members of the public, and other HHS operating divisions. The WGM noted that the 2022 guidelines caution against the implementation of dosage limits such as those set out in the OHD-AD measure and emphasize the importance of flexibility in meeting the care needs and clinical circumstance of each patient. Notably, the Guideline[4] states that it is not intended to be applied as inflexible standards of care across patients or patient populations by health care professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions.

The WGM suggested that the measure does not account for implementation considerations because it fails to account for the nuances of providing pain care. The WGM pointed out the differences in treatment between prescribing opioid-naïve patients with initial low dosages and reducing long-term high dosages for patients, a process requiring substantial care to avoid harms.[5] The WGM then compared 2016 dosage management guidelines to observed clinical practices, and found that although the guidelines specifically recommended not *increasing* dosages above 90 MME daily, in practice, clinicians *reduced* dosages of patients already receiving 90 or more MME daily. In many cases, clinicians reduced dosages rapidly in patients receiving and dependent on higher dosages, even though the 2016 guideline recommended against rapid dosage reduction.[6]

The WGM commented that OHD-AD incentivizes rapid dosage reduction, as that is the most expedient way to have a greater proportion of patients below the threshold.[b] The WGM stated that preventing dosage increases early on is more important for preventing long-term harm. The WGM called for greater nuance in addressing the harms of high opioid dosages, pointing out that once patients are on higher dosages, there are associated harms with both remaining on and reducing those high dosages. For this reason, the 2022 Clinical Practice Guideline included the two separate recommendations on dosage management.

[a] In response to this statement, the measure steward pointed out that the 2025 Core Sets Annual Review Workgroup voted to recommend retaining the measure due to its strategic importance amidst the ongoing opioid epidemic. For more information, please see the 2025 Child and Adult Core Sets Annual Review: Final Report, available at: https://mathematica.org/features/MACCoreSetReview.

[b] In response to this statement, the measure steward commented that instances of unintended consequences associated with the measure have not been observed. They also noted that the OHD measure specifications explicitly state that it is not intended as a rigid or inflexible standard of care.

Finally, the WGM highlighted the data on dose and duration in the 2022 Clinical Practice Guideline as a resource to provide contextual information for clinicians but warned against rigid application of these data. The WGM cited the guidelines, noting that, "recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making."[7]

Other Considerations

The WGM encouraged CMS to remove OHD-AD, to support implementation of the *2022 Clinical Practice Guideline for Prescribing Opioids for Pain* and to allow for maximum flexibility and care for treatment of patients living with pain, which is a key element of the updated guidelines. The WGM reiterated this measure's conflict with Goal 3 of the CMS Behavioral Strategy, noting that a standardized population-level measure on prescription opioid dosages does not capture the individualized nuance that evidence-based pain care necessitates and leaves out important patient care and safety concerns that are cited in the 2022 Clinical Practice Guideline. The WGM suggested that inclusion of this measure would result in inconsistent messaging among HHS operating divisions regarding the use of opioids to treat patients living with pain.

Finally, the WGM reaffirmed their stance to remove OHD-AD by highlighting alternative efforts to mitigate and assess the harms of high opioid dosages. For example, the CDC is developing new clinician education and communication materials that is being released throughout 2023, which includes opioid prescribing resources[8] and trainings[9] to assist clinicians and other healthcare personnel with providing patient-centered care. The WGM also noted that the CDC is engaging with professional organizations to support implementation and develop tailored materials. The WGM suggested that as the CDC continues this work, CMS may wish to promote and/or utilize CDC-developed education and communication materials to support safe, effective pain care and opioid prescribing.

Core Set Reporting History

Year added to Core Set	2016
Number of states reporting the measure	FFY 2020: 33 states (5 states reported using other specifications) FFY 2021: 36 states (6 states reported using other specifications) FFY 2022: 40 states (6 states reported using other specifications) States that reported the measure using "other" specifications reported the HEDIS *Use of Opioids at High Dosage* measure.
Was the measure publicly reported for FFY 2022?	Yes (see the following pages for FFY 2022 data)
Is the measure on the Medicaid & CHIP Scorecard?	Yes
Challenges noted by states in reporting the measure for FFY 2022	Data not available (5 states) due primarily to information not collected. States also noted: • Lack of resources to report. • Unanticipated staff turnover resulting in an inability to report. • Resource and timing constraints. • This is not one of the measures the state prioritized to track Medicaid performance. One state indicated they intend to report this measure by 2024.

Summary of prior Workgroup discussions	This measure was discussed at the 2021, 2023, and 2025 Core Set Annual Review meetings, but was not recommended for removal from the Adult Core Set. Note that at the time of the 2021 and 2023 Annual Review meetings, the measure was included in and discussed as part of the Behavioral Health Care domain. CMS moved this measure to the Care of Acute and Chronic Conditions domain beginning with the 2023 Adult Core Sets. At the 2021 Core Set Annual Review Meeting, a WGM suggested this measure for removal because it measures how chronic pain is treated and does not reflect performance of the behavioral health care system. During the discussion, other WGMs agreed that, while the measure is not strictly a behavioral health measure, it emphasizes the importance of measuring opioid prescribing and misuse in responding to the opioid epidemic. One WGM indicated that over-prescribing is associated with several adverse medical outcomes beyond addiction. Another noted that this is the only measure in the Core Set that makes prescribers and pharmacies accountable for overprescribing, over dispensing, and overuse of opioids. At the 2023 Core Set Annual Review Meeting, a WGM suggested this measure for removal because the measure may not be leading to improvements in quality of care and outcomes, and because the opioid epidemic is no longer driven by prescription opioids. During the discussion, a WGM commented that a third of the measures in the Adult Core Set fall under the Behavioral Health Care domain, with four measures focused on opioids, and suggested prioritizing measures that are actionable. However, other WGMs were hesitant to remove the measure because of rising rates of opioid overdoses and deaths during the COVID-19 pandemic. Several WGMs noted that OHD-AD measures appropriateness of pain management and integration between pharmacies and providers, rather than opioid abuse. Another WGM commented that although there may be some instances of physicians unnecessarily tapering patients' medications to improve performance on the measure, far more patients will be protected from high-risk doses. WGMs suggested that the Workgroup discuss the measure again during the 2025 Annual Review for two reasons. One WGM cited recent changes with CDC's new 2022 Clinical Practice Guideline for Prescribing Opioids for Pain and the shift of the opioid overdose epidemic from prescription opioids to illicit opioids. Another WGM suggested revisiting the measure with a focus on the monitoring that occurs under the DUR requirements, which are focused on appropriate prescribing. During the 2025 Annual Review, PQA, the measure steward, indicated they were considering retiring the measure following the CDC's decision to discontinue the morphine milligram equivalents (MME) Conversion File, a tool needed to calculate the measure. However, WGMs expressed their concern about the CDC discontinuing file updates and ultimately supported retaining the measure due to its strategic importance amidst the ongoing opioid epidemic.

Other	The WGM who suggested this measure for removal from the 2026 Core Set noted that the measure merited discussion again because of the lack of alignment with federal policy strategies and goals. The measure steward indicated that they do not plan to retire the OHD-AD measure. Although the Opioid NDC and Oral MME Conversion File has been discontinued, they received feedback from a variety of PQA stakeholders that the measure remains an evidence-based and critical medication safety measure. PQA is evaluating alternative sources for MME conversions, including the MME conversion table provided in the CDC's *2022 Clinical Practice Guideline for Prescribing Opioids for Pain,* to determine impact and appropriateness for the OHD measure. These changes will occur through PQA's systematic, transparent, and consensus-based maintenance process and, if approved, will be finalized for measurement year 2025.

Citations

[1] *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multistakeholder Review of the 2021 Child and Adult Core Sets. Final Report.* August 2020. Available at: https://mathematica.org/features/MACCoreSetReview.

[2] https://www.cms.gov/cms-behavioral-health-strategy.

[3] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm#B2_down.

[4] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm#B2_down.

[5] https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf.

[6] https://www.fda.gov/drugs/fda-drug-safety-podcasts/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes#:~:text=On%20April%209%2C%202019%20FDA,%2C%20psychological%20distress%2C%20and%20suicide.

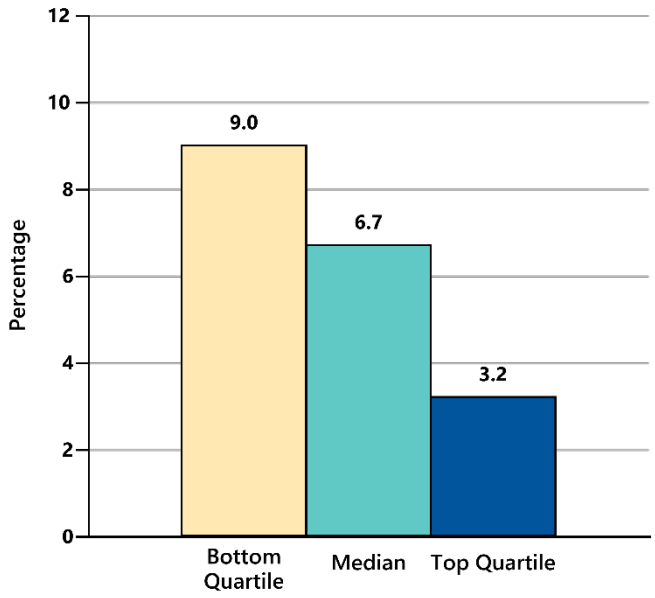
[7] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.

[8] https://www.cdc.gov/opioids/healthcare-professionals/prescribing/index.html.

[9] https://www.cdc.gov/opioids/healthcare-professionals/training/index.html.

Percentage of Adults Ages 18 to 64 Without Cancer who Received Prescriptions for Opioids with an Average Daily Dosage Greater than or Equal to 90 Morphine Milligram Equivalents (MME) for a Period of 90 Days or More (OHD-AD), FFY 2022 (n = 32 states)

[Lower rates are better for this measure]



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: This measure shows the percentage of adults aged 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more during the measurement year. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded. States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and older. This chart shows reporting for the Ages 18 to 64 rate. However, some states may have reported a rate for age 18 and older. This chart excludes New Jersey, New York, Ohio, Pennsylvania, Texas, and Virginia, which calculated the measure but did not use Adult Core Set specifications. Data were suppressed for North Dakota and Puerto Rico due to small cell sizes.

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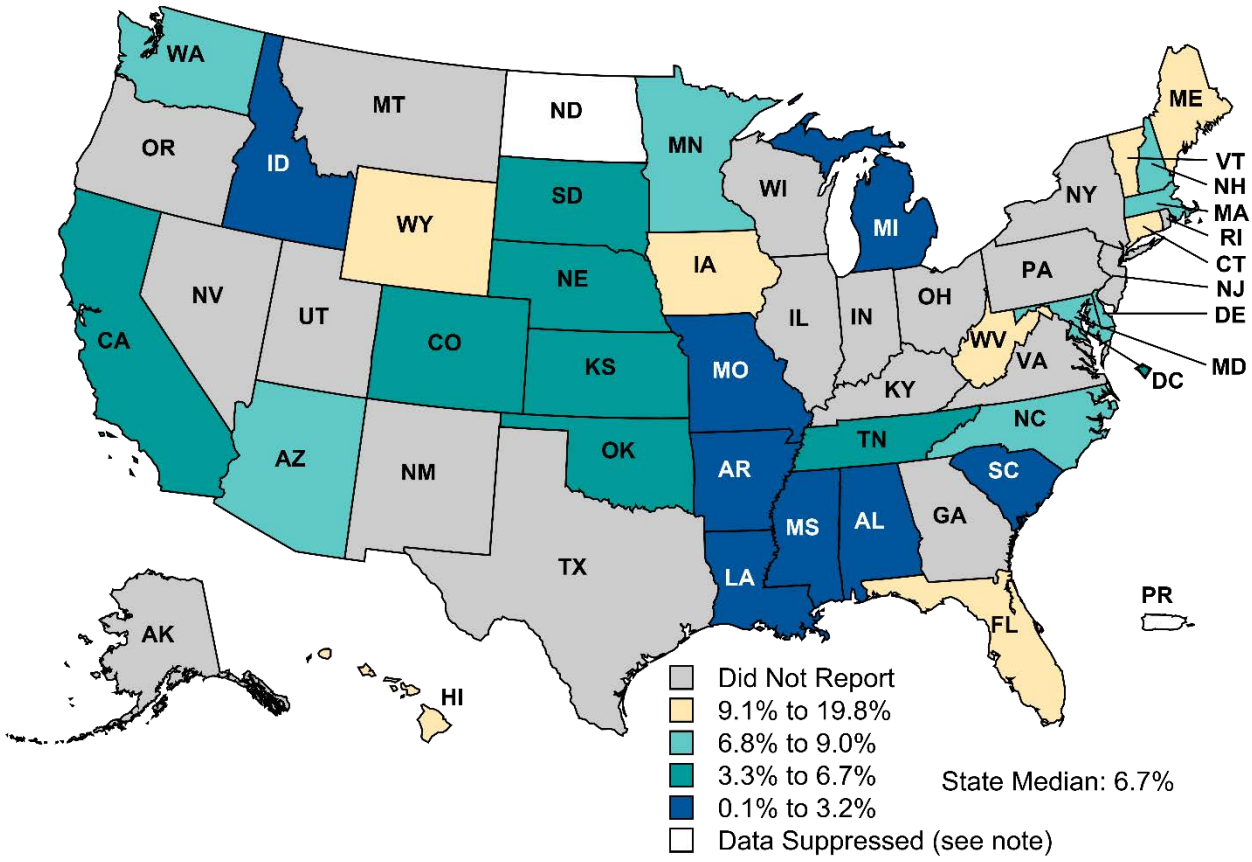
Geographic Variation in the Percentage of Adults Ages 18 to 64 Without Cancer who Received Prescriptions for Opioids with an Average Daily Dosage Greater than or Equal to 90 Morphine Milligram Equivalents (MME) for a Period of 90 Days or More (OHD-AD), FFY 2022 (n = 32 states)

[Lower rates are better for this measure]



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and older. This chart shows reporting for the Ages 18 to 64 rate. However, some states may have reported a rate for age 18 and older. This chart excludes New Jersey, New York, Ohio, Pennsylvania, Texas, and Virginia, which calculated the measure but did not use Adult Core Set specifications. Data were suppressed for North Dakota and Puerto Rico due to small cell sizes.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR REMOVAL FROM THE 2026 CORE SETS

Measure Information	
Measure name	**Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)**
Description	Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • **Initiation of SUD Treatment.** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. • **Engagement of SUD Treatment.** The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Measure steward	National Committee for Quality Assurance (NCQA)
Core Set	Adult Core Set
Core Set domain	Behavioral Health Care
Meaningful Measures area	Behavioral Health
Measure type	Process
If measure is removed, does it leave a gap in the Core Set?	No. The Workgroup member (WGM) who suggested this measure for removal indicated that removing the measure would not leave a gap in the Core Set.
Has another measure been proposed for substitution (new or existing measure)?	No
Is there another related measure in the Core Set?	• Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) • Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)
Use in other CMS programs	• Merit-Based Incentive Payment System Program • Marketplace Quality Rating System • Medicaid Health Home Core Set

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FFY 2024 Technical Specifications	
Ages	Age 18 and older as of the SUD episode date.
Data collection method	Administrative or electronic health records (EHR).
Denominator	The number of new substance use disorder episodes for beneficiaries age 18 and older as of the SUD episode date.
Numerator	• **Numerator 1: Initiation of SUD Treatment** – Step 1: If the SUD episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the SUD episode is compliant. – Step 2: If the SUD episode was an opioid treatment service that bills monthly, the opioid treatment service is considered initiation of treatment and the SUD episode is compliant. – Step 3: For remaining SUD episodes (those not compliant after steps 1–2), identify episodes from the qualifying episode list with at least one SUD episode date on or during the 13 days after the SUD episode date (14 total days). • **Numerator 2: Engagement of SUD Treatment** – Step 1: Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment. – Step 2: Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant. – Step 3: Identify SUD episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD episode is compliant. – Step 4: For remaining SUD episodes identify episodes with at least two of the qualifying engagement visits or engagement treatment events (any combination) on the day after the initiation encounter through 34 days after the initiation event.
Exclusions	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services anytime during the measurement year. • Beneficiaries who died any time during the measurement year.
Continuous enrollment period	194 days prior to the SUD episode date through 47 days after the SUD episode date (242 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.

Reasons for Removal Noted by Workgroup Member(s)

Minimum Technical Feasibility Criteria

None identified by the WGM.

Actionability and Strategic Priority

None identified by the WGM.

Other Considerations

The WGM noted that this measure changed to an event-based measure for HEDIS MY 2022 (2023 Adult Core Set), whereas before it was specified at the individual level. The WGM explained that due to this change, there is now overlap with similar measures, including FUA-AD and OUD-AD. The WGM suggested there is not a need for similar measures looking at care processes in a slightly different way.

Core Set Reporting History

Year added to Core Set	2013 (Initial Adult Core Set) Note: For the 2023 Core Set, the measure name changed from "Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment" to "Initiation and Engagement of Substance Use Disorder Treatment"
Number of states reporting the measure[c]	FFY 2020: 40 states (all states reported calculating the measure using Core Set specifications) FFY 2021: 40 states (all states reported calculating the measure using Core Set specifications) FFY 2022: 46 states (all states reported calculating the measure using Core Set specifications)
Was the measure publicly reported for FFY 2022?	Yes (see the following pages for FFY 2022 data)
Is the measure on the Medicaid & CHIP Scorecard?	Yes
Challenges noted by states in reporting the measure for FFY 2022	Data not available (3 states) due to staff constraints and information not collected by providers. A fourth state noted lack of resources to report.

[c] In HEDIS MY 2022 (which corresponds to the 2023 Core Set), NCQA changed the IET-AD measure to an episode-based measure from a member-based measure. All state reporting data in this document refer to the previous version of IET-AD.

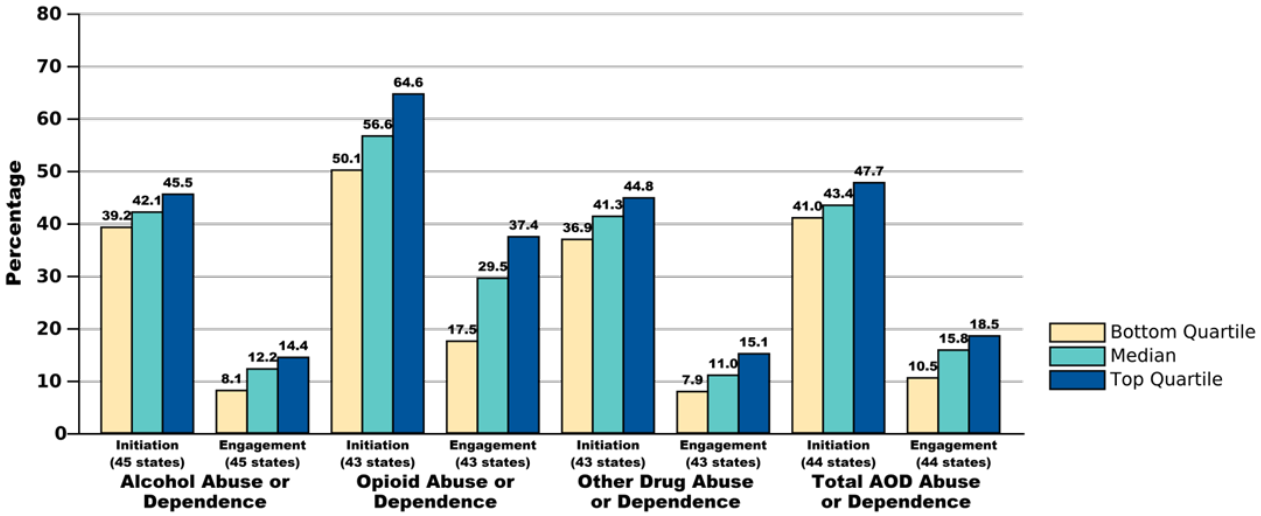
Summary of prior Workgroup discussions	IET-AD was suggested for removal from the 2022 Adult Core Set. At the time, a WGM suggested this measure for removal because it is duplicative of other Core Set measures such as FUA-AD and OUD-AD, and because the measure focuses on new substance use events and does not consider an existing substance use event. Other WGMs expressed concern that removing the measure could leave a gap in the Core Set because it is broader in scope and settings than the FUA-AD and OUD-AD measures. IET-AD addresses treatment for the general population, while FUA-AD addresses follow-up care for the population that ends up in the ER. While one WGM noted that the measure could incentivize health systems to ensure that patients are receiving proper care when they are identified as having substance use or dependence, a federal liaison suggested that the IET-AD measure could potentially discourage providers from reporting a diagnosis of SUD to "activate" the measure. Ultimately, the Workgroup voted not to recommend IET-AD for removal.
Other	Starting with HEDIS MY 2022 (2023 Adult Core Set), NCQA made several substantive changes to the IET-AD measure. As previously noted, they revised the measure name to Initiation and Engagement of Substance Use Disorder Treatment. They also changed the measure from "member-based" to "episode-based;" changed the denominator to lengthen the negative SUD history period from 60 days to 194 days and remove ED visits and medically managed withdrawal from the negative SUD history period; removed the numerator requirement that psychosocial treatment accompany pharmacotherapy; and revised the age stratifications to reflect ages 18–64 years and 65+ years.[1] Beginning with FFY 2025 Adult Core Set reporting, states will be expected to stratify the IET-AD measure by three separate categories using established data standards as follows:[2] • Race and ethnicity, using the disaggregation of the 1997 Office of Management and Budget minimum race and ethnicity categories, as specified in the 2011 HHS standards; • Sex, defined as biologic sex, using the 2011 HHS standards; and • Geography, using a minimum standard of core-based statistical area with recommendation to move toward Rural-Urban Commuting Area Codes. Note that the HEDIS MY 2024 specifications for this measure also require stratification by race and ethnicity. NCQA indicated they have not assessed the feasibility of stratifying this measure by additional factors such as sex, rural/urban status, disability, or language.

Citations

[1] https://www.ncqa.org/blog/hedis-2022-see-whats-new-whats-changed-and-whats-retired/#:%7E:text=NCQA%20introduced%20race%20and%20ethnicity,and%20Adolescent%20Well%20Care%20Visits.

[2] https://www.medicaid.gov/sites/default/files/2023-12/sho23005.pdf.

Percentage of Adults Ages 18 to 64 with a New Episode of Alcohol or Other Drug Dependence who: (1) Initiated Treatment within 14 Days of the Diagnosis, and (2) Initiated Treatment and were Engaged in Ongoing Treatment within 34 Days of the Initiation Visit (IET-AD), FFY 2022



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: This measure shows the percentage of adults age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who: (1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis (initiation rate); and (2) initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit (engagement rate). States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older.

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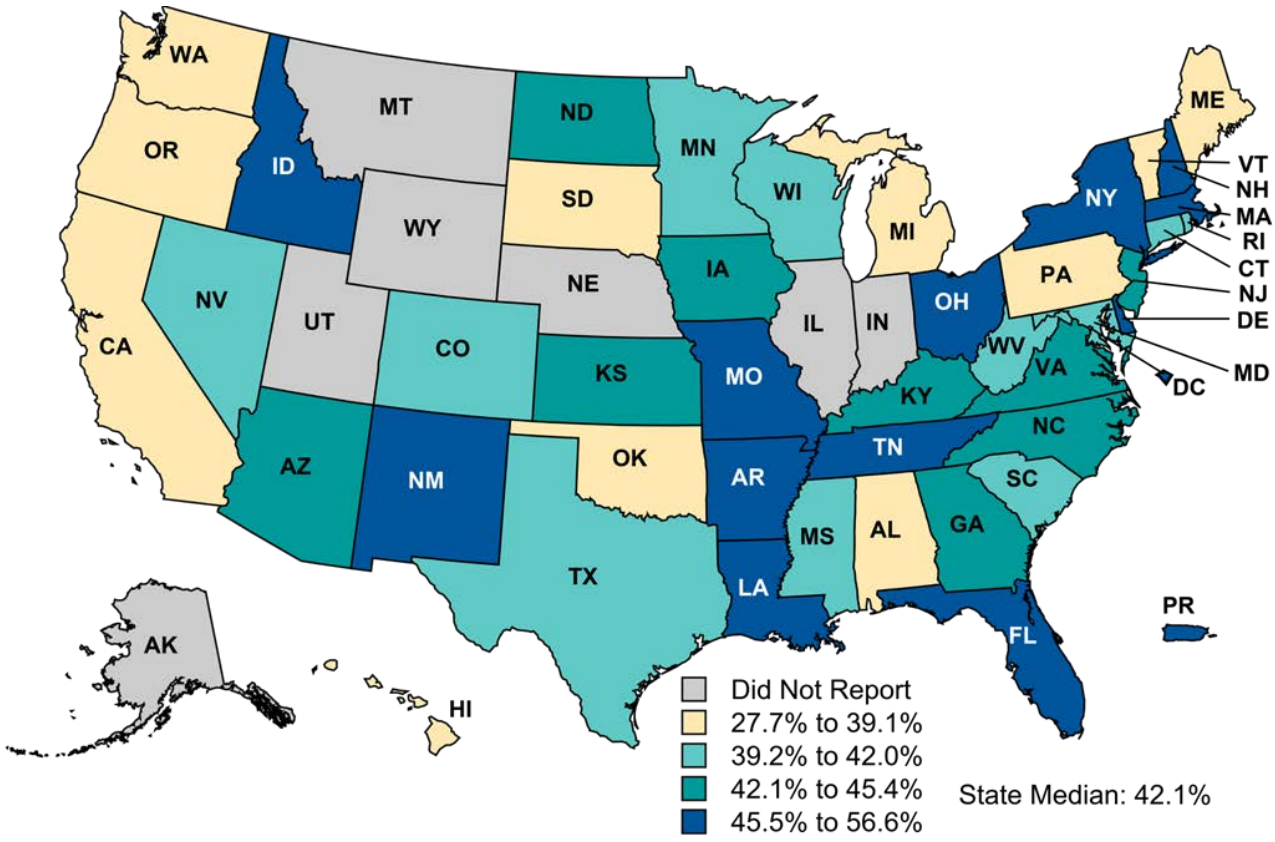
Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Alcohol Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis (IET-AD), FFY 2022 (n = 45 states)



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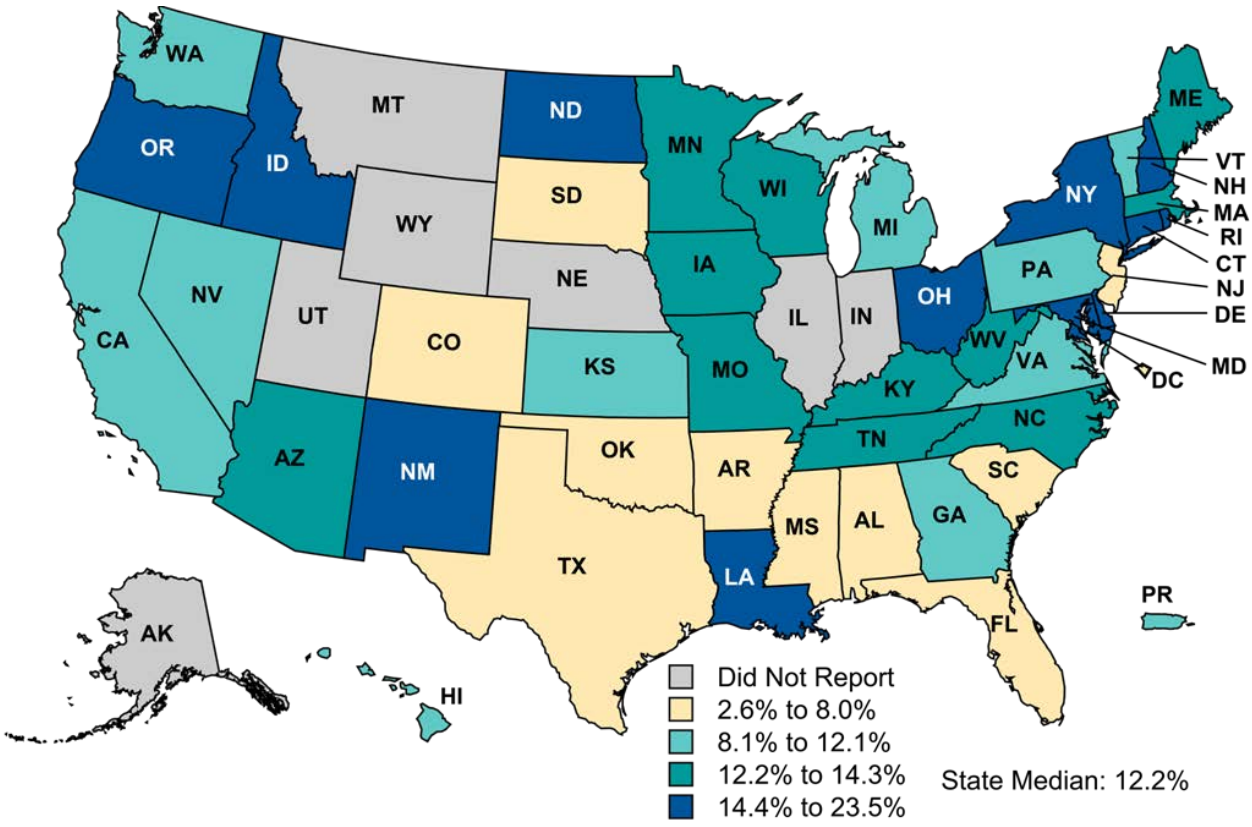
Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Nebraska, which reported the measure but did not provide data for the Initiation of Alcohol Abuse or Dependence Treatment rate.

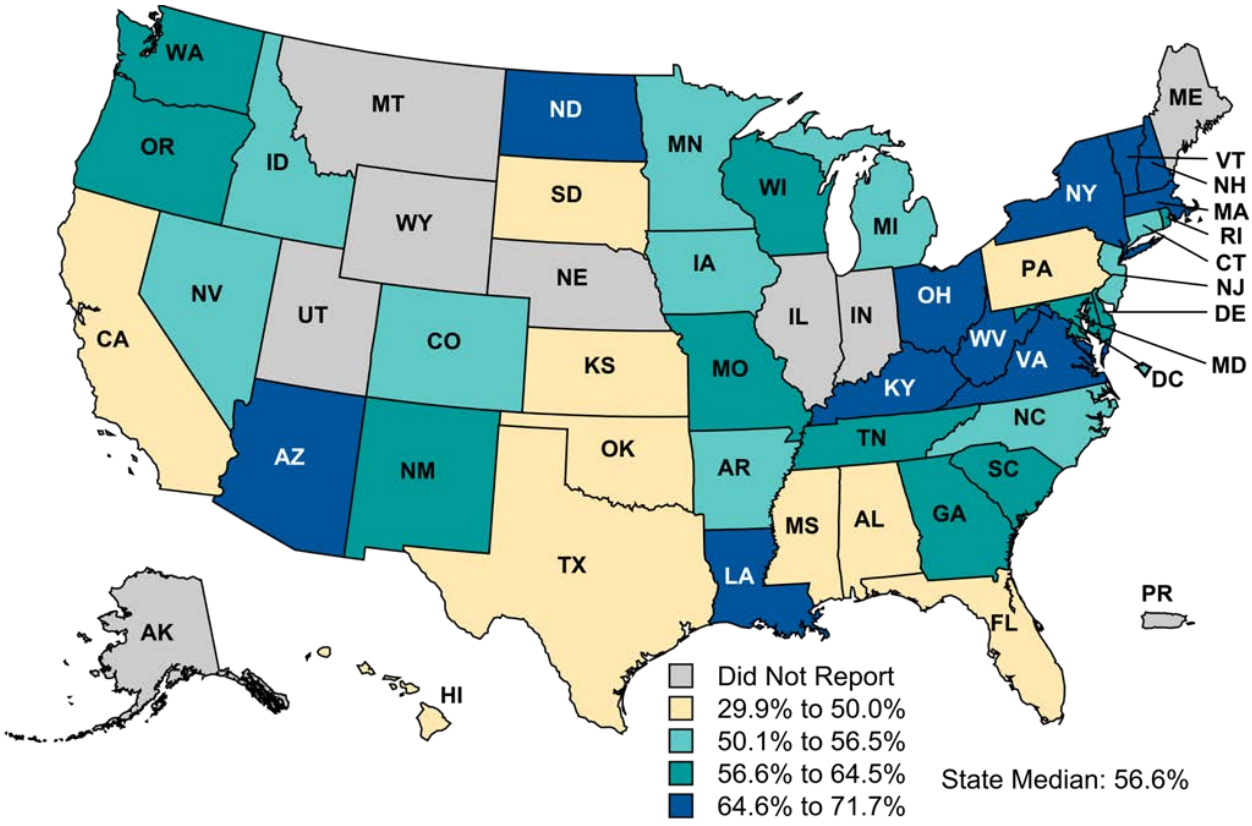
Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Alcohol Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit (IET-AD), FFY 2022 (n = 45 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Nebraska, which reported the measure but did not provide data for the Engagement of Alcohol Abuse or Dependence Treatment rate.

Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Opioid Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis (IET-AD), FFY 2022 (n = 43 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Maine, Nebraska, and Puerto Rico, which reported the measure but did not provide data for the Initiation of Opioid Abuse or Dependence Treatment rate.

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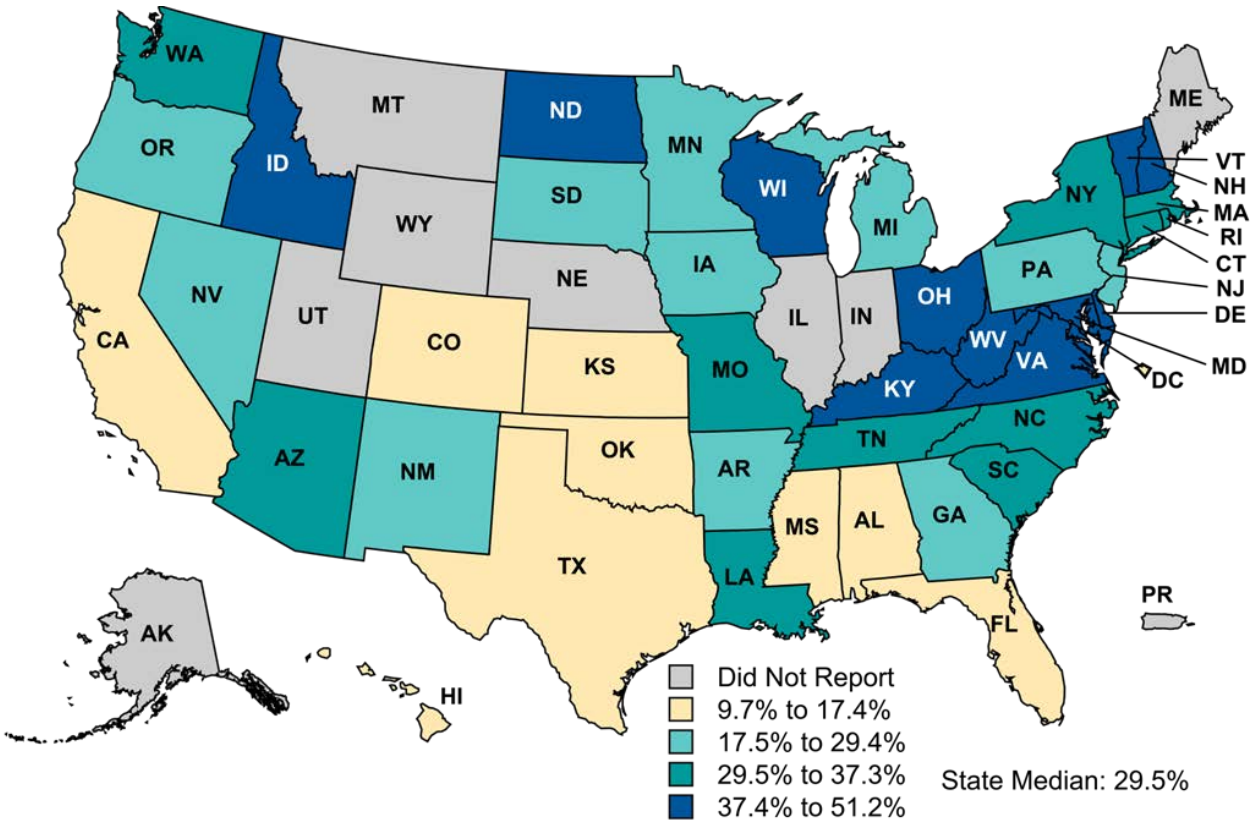
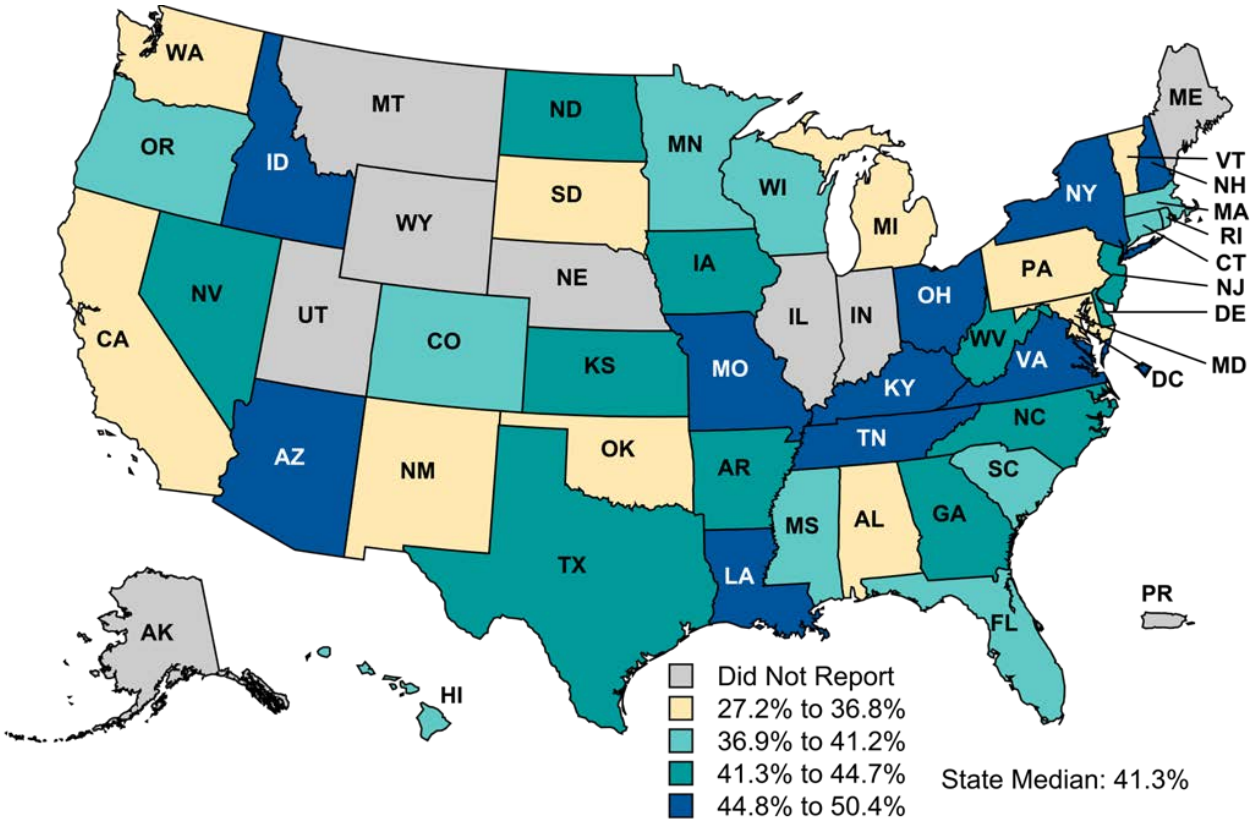
Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Opioid Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit (IET-AD), FFY 2022 (n = 43 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Maine, Nebraska, and Puerto Rico, which reported the measure but did not provide data for the Engagement of Opioid Abuse or Dependence Treatment rate.

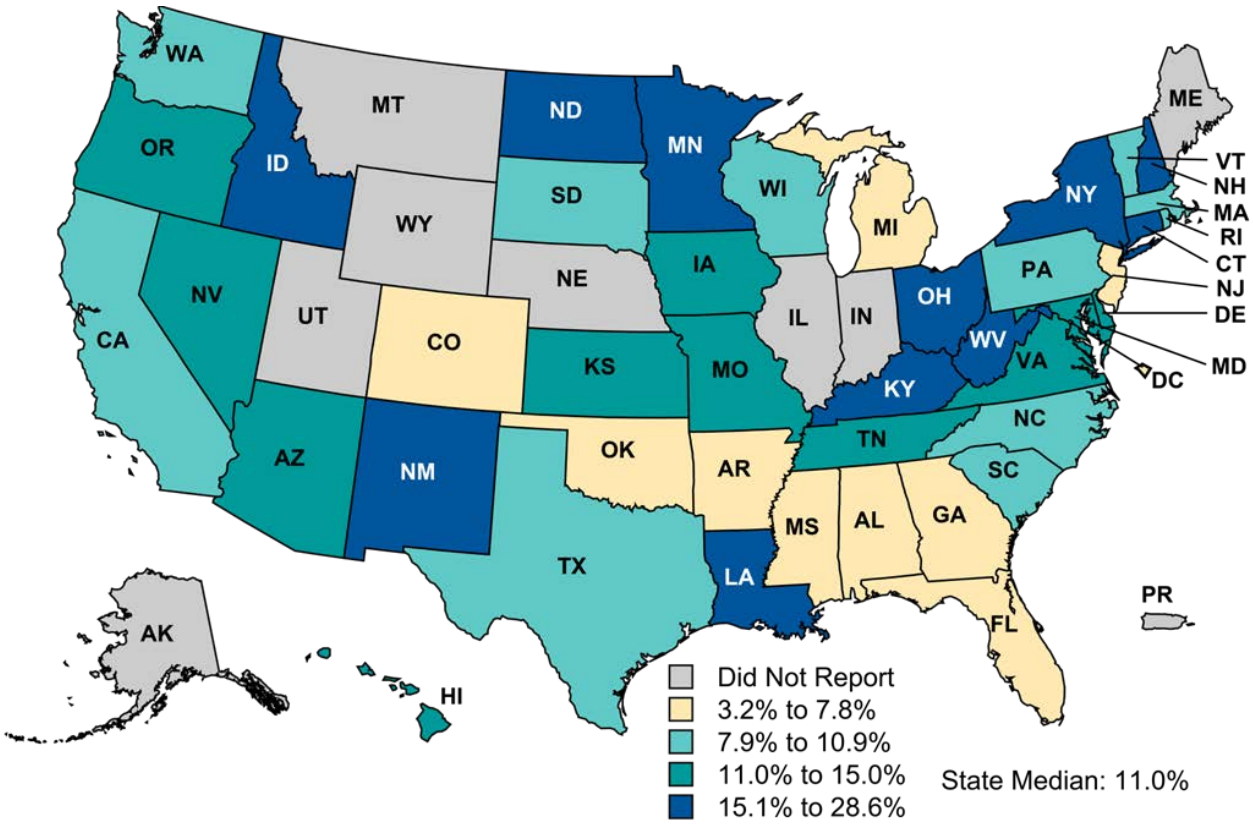
Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis (IET-AD), FFY 2022 (n = 43 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Maine, Nebraska, and Puerto Rico, which reported the measure but did not provide data for the Initiation of Other Drug Abuse or Dependence Treatment rate.

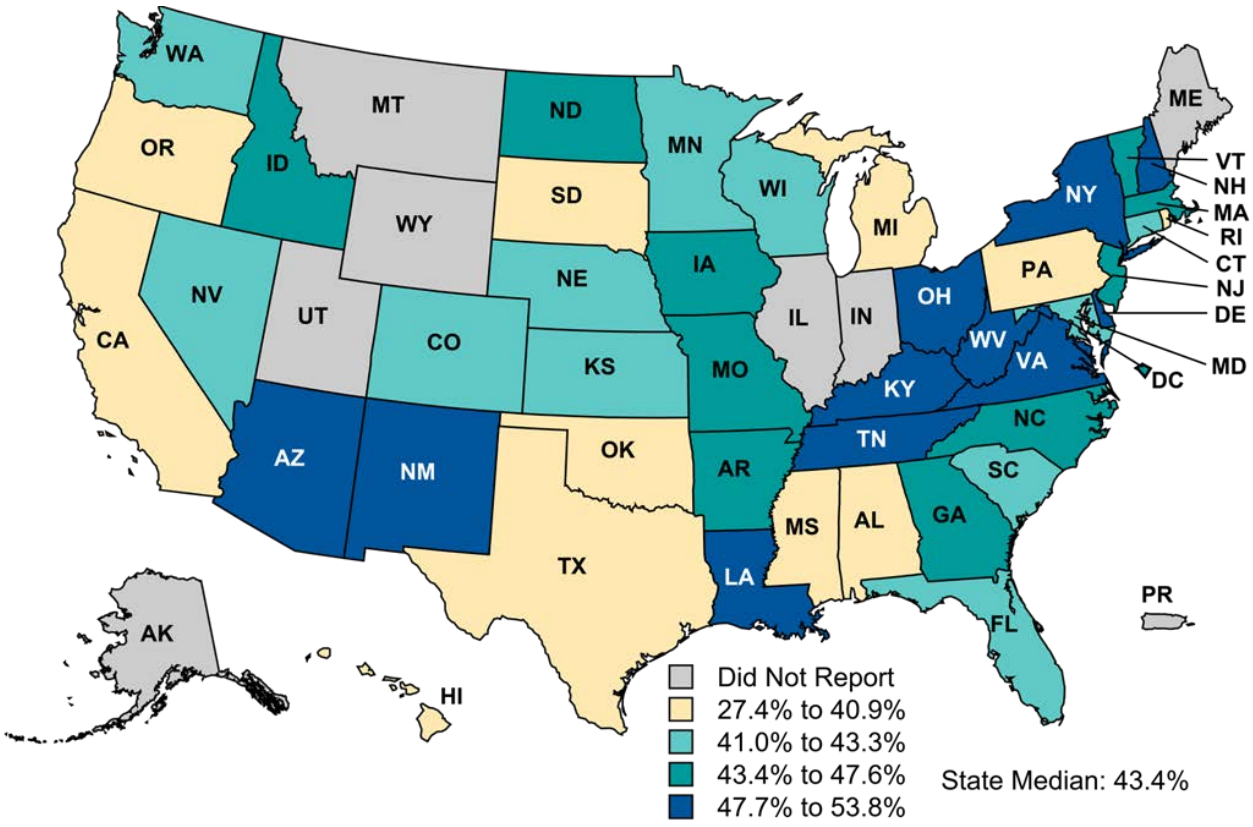
Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation (IET-AD), FFY 2022 (n = 43 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Maine, Nebraska, and Puerto Rico, which reported the measure but did not provide data for the Engagement of Other Drug Abuse or Dependence Treatment rate.

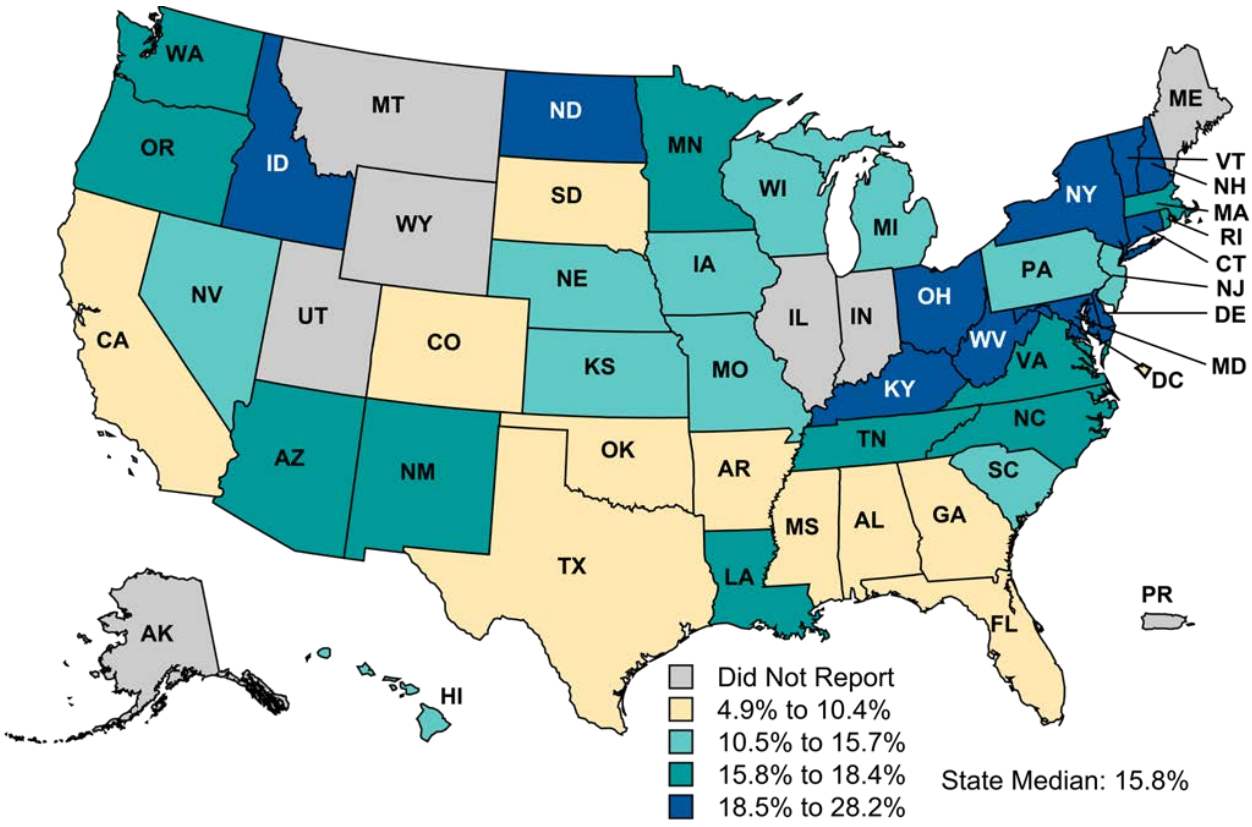
Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated Alcohol or Other Drug Treatment within 14 Days of the Diagnosis (Total Rate) (IET-AD), FFY 2022 (n = 44 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Maine and Puerto Rico, which reported the measure but did not provide data for the Total Initiation rate.

Geographic Variation in the Percentage of Adults Ages 18 to 64 with a New Episode of Alcohol or Other Drug Abuse or Dependence who Initiated and Engaged in Alcohol or Other Drug Treatment within 34 Days of the Initiation Visit (Total Rate) (IET-AD), FFY 2022 (n = 44 states)



Source: Mathematica analysis of the Quality Measure Reporting (QMR) system reports for the Adult Core Set for the FFY 2022 reporting cycle as of June 1, 2023. Additional information (including state-specific rates and comments and data notes) is available at: https://www.medicaid.gov/media/163316.

Notes: States report two age stratifications for this measure for the Adult Core Set: Ages 18 to 64 and Age 65 and Older. This chart shows reporting for the Ages 18 to 64 rates. However, some states may have reported rates for Age 18 and older. This chart excludes Maine and Puerto Rico, which reported the measure but did not provide data for the Total Engagement rate.

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Measures Suggested for Addition

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2026 CORE SETS

Measure Information	
Measure name	**Prenatal Depression Screening and Follow-up**
Description	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported: 1. **Depression Screening.** The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. 2. **Follow-Up on Positive Screen.** The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
Measure steward	National Committee for Quality Assurance (NCQA)
Core Set domain	To be determined by CMS
Meaningful Measures area(s)	Behavioral Health
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)

Denominator	The measure includes denominators for two rates:
	1. **Depression Screening.** Deliveries during the measurement period (January 1–December 31) that meet the following criteria:
	  1. Meet requirements for participation.*
	  2. Have a gestational age assessment or gestational age diagnosis within 1 day of the delivery date (see Exclusions).
	2. **Follow-Up on Positive Screen.** All deliveries from the Depression Screening numerator with a positive finding for depression during pregnancy.

Denominator (continued)	* Participation is defined as the identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Participation includes both allocation and continuous enrollment: • Allocation criteria: The member was enrolled with a medical benefit 28 days prior to the delivery date through the delivery date. Continuous enrollment criteria: See below.
Numerator	The measure includes numerators for two rates: 1. **Depression Screening.** Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening instrument, performed during pregnancy (on or between pregnancy start date and the delivery date). • Deliveries between January 1 and December 1 of the measurement period: Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date). • Deliveries between December 2 and December 31 of the measurement period: Screening should be performed between the pregnancy start date and December 1 of the measurement period. 2. **Follow-Up on Positive Screen.** Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 days total). Follow-up care is defined as any of the following: • An outpatient antidepressant, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. • A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. • A dispensed medication. *or* • Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Numerator (continued)

Eligible screening instruments with thresholds for positive findings for this measure are:

Instruments for Adolescents (≤17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®^	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®^*	Total score ≥ 8
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10
PROMIS Depression	Total score (T Score) ≥ 60

^ Brief screening instrument. All other instruments are full-length.

* Proprietary; may be cost or licensing requirement associated with use.

Instruments for Adults (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total score ≥ 10
Patient Health Questionnaire-2 (PHQ-2)®^	Total score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)®^*	Total score ≥ 8
Beck Depression Inventory (BDI-II)	Total score ≥ 20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total score ≥ 17
Duke Anxiety-Depression Scale (DUKE-AD)®*	Total score ≥ 30
Edinburgh Postnatal Depression Scale (EPDS)	Total score ≥ 10
My Mood Monitor (M-3)®	Total score ≥ 5
PROMIS Depression	Total score (T Score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	Total score ≥ 31

^ Brief screening instrument. All other instruments are full-length.

* Proprietary; may be cost or licensing requirement associated with use.

Exclusions	All measure rates exclude the following:
	• Deliveries that occurred at less than 37 weeks gestation. Length of gestation in weeks is identified by one of two methods:
	  • Gestational age assessment (SNOMED CT code 412726003; value < 37 weeks), or
	  • Gestational age diagnosis (Weeks of Gestation Less Than 37 Value Set).
	• All episodes for members who use hospice services or elect to use a hospice benefit any time during the measurement period.
	• Members who die any time during the measurement period.

Continuous enrollment period	The member was enrolled 28 days prior to the delivery date through the delivery date, with no gaps in enrollment.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2024 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	Prior to adding this measure to HEDIS, NCQA tested this measure at the health plan level in Washington, DC and Hawaii and at the provider organization level in New York and Colorado. Since then, NCQA has continued to assess Medicaid plans' use and reporting of the measure through a series of special reports on measures leveraging the ECDS reporting standard. Reports from November 2021[1] and November 2022[2] are available online. The Workgroup member (WGM) who suggested the measure for addition noted that the detail regarding which state Medicaid agencies reported the measure is not available in these reports. However, health plan and Medicaid agency guidance can be found on the web. Examples include: • California Department of Health Care Services[3] • North Carolina BlueCross BlueShield – Healthy Blue Plan (plan-level)[4] • New Jersey Horizon Blue (plan-level)[5] • Pennsylvania Medicaid began requiring Medicaid health plans to report the measure beginning in 2020.

Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM who suggested the measure did not note any barriers, limitations, or variations. The November 2022 special report from NCQA indicated that performance rates varied by data sources used for reporting. For example, all plans that only used claims data reported a performance rate of zero for the screening indicator in MY 2021, while plans that incorporated any electronic clinical data reported an average performance rate of 15.7 percent.[6] NCQA confirmed similar results in more recent data showing the average performance rate for the screening indicator was zero percent among plans that used claims data only compared to 9-15 percent among plans that used any non-claims data source.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that the health of mothers and women is critical to the health of our nation, and mothers and their children enrolled in Medicaid and CHIP are particularly vulnerable to maternal depression and the harmful effects when untreated.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM suggested that the data could be stratified at a minimum by race, ethnicity, sex, and age. The HEDIS MY 2024 measure specifications include stratifications by race and ethnicity for the Medicaid product line. The specifications indicate that the race and ethnicity stratifications data source logic is not included in the measure calculation logic, and must be programmed manually. The measure steward has not assessed feasibility to stratify the measure by age, sex, rural/urban status, disability, and language at this time.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM cited NCQA, the measure developer, as stating: "Women with untreated depression during pregnancy are at risk for developing severe postpartum depression and suicidality and of delivering premature or low birth-weight infants. Postpartum depression hinders important caregiving activities and infant attachment and bonding, which can lead to developmental disorders that last into adolescence."[7] The WGM noted that maternal mental health disorder research initially focused on postpartum depression, which is why health care providers tend to focus on postpartum depression. However, many studies point to an increased prevalence of depression in pregnancy, including a recent systematic review: prevalence of prenatal (antenatal) depression and postnatal depression was 28.5 percent and 27.6 percent, respectively.[8] The WGM indicated that prenatal depression screening is recommended, given the impact on the developing fetus and the increased risk of severe postpartum depression:

How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery (continued)	• Since 2019, the U.S. Preventive Services Task Force has recommended screening pregnant women for depression. • The Alliance for Innovation in Maternal Health (AIM)'s perinatal mental health conditions bundle includes the following: "Screen for depression and anxiety at the initial prenatal visit, later in pregnancy…"[9] • The American College of Obstetricians and Gynecologists (ACOG) notes untreated perinatal depression and other mood disorders can have devastating effects. ACOG published clinical practice guidelines and a toolkit recommending screening occur after the initial prenatal visit, later in pregnancy.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM explained that, while the measure is relatively new and one of the first e-measures, there is evidence that illustrates improved outcomes when states and health plans lead QI initiatives to improve maternal depression outcomes. Multiple studies have illustrated interventions like provider education and support can improve maternal depression screening and follow-up outcomes.[10]
How measure can be used to monitor improvement	The WGM explained there is certainly room for performance on these measures to be improved. Among Medicaid plans that reported the measure for MY 2021 (and had rates greater than zero), prenatal depression screening occurred 16 percent of the time. The WGM indicated that Medicaid agencies can improve rates through various efforts, most notably: • Promote mental health integration in primary care/obstetric settings, and address carveouts for mental health (calling on plans to integrate contracts for behavioral health in medical care contracts). One example is the Inland Empire Health Plan which integrated behavioral health into medical care by working with contracted clinics.[11] • Publish screening reimbursement guidelines and encourage the development of case management programs. For example, Virginia reimburses three maternal depression screenings during pregnancy. Further, Virginia recommends that when an enrollee has a positive screen, an MCO care coordinator track and provide referrals. • Implement value-based payments, such as pay for performance or even fee-for-service reimbursement.[12] • Require plans to publish perinatal mental health certified (PMH-C) providers in provider directories (Arizona's Medicaid agency is in the early stages of implementation). The WGM also cited Texas's maternal depression strategic plan.[13]

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM indicated that it's well documented that low-income women are at higher risk for maternal depression and that those enrolled in Medicaid are also at greater risk than those covered by commercial insurance. One study notes that the prevalence of postpartum depression symptoms is higher among people whose childbirth care is paid for by Medicaid (17 percent) than for people with a commercial payer during childbirth (10 percent).[14] According to the November 2022 NCQA report on plan performance on the prenatal depression screening measure in MY 2021, the mean Medicaid HMO performance rate for screening was 15.7 percent and the mean Medicaid HMO performance rate for follow-up was 49.7 percent.[15]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM referred to the November 2022 NCQA report: "Reporting results showed that there has been a steady increase in ECDS reporting. The contributions from EHR, HIE/registry and case management data sources continue to increase, demonstrating that more plans are seeking information beyond claims for quality measurement. However, challenges persist particularly regarding standardized data capture of behavioral health information at the point of care, and there may not be sharing of relevant information between health care systems. Improved health plan reporting, and measure performance are feasible with strategic multistakeholder approaches that drive better use and sharing of electronic clinical data. Public reporting of HEDIS measures using ECDS reporting is a critical step in the use of clinical data systems to measure quality."[16] Additionally, the WMG noted that any barriers related to the postpartum depression screening and follow-up measure discussed by the Workgroup in prior years may apply to this measure as well.
Summary of prior Workgroup discussions	This measure was discussed at the 2020 and 2021 Core Sets Annual Review meetings. At the 2020 meeting, the measure was not recommended for addition to the Core Sets because of concerns with the measure being new and untested at the state level as well as using a new data collection method. At the 2021 meeting, the measure was discussed again, in conjunction with the *Postpartum Depression Screening and Follow-Up* measure. Much of the discussion about the measures focused on the postpartum measure, with several Workgroup members emphasizing the relationship between postpartum depression and infants' social and emotional development. The Workgroup prioritized recommending the *Postpartum Depression Screening and Follow-Up* measure, and did not recommend the *Prenatal Depression Screening and Follow-Up* measure for addition to the 2021 Core Sets.

Citations

[1] https://www.ncqa.org/wp-content/uploads/2021/11/Special-Report-Reporting-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.

[2] https://www.ncqa.org/wp-content/uploads/2022/11/Special-Report-Nov-2022-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.

[3] https://www.dhcs.ca.gov/Documents/MCQMD/MY2022-RY2023-MCAS.pdf.

[4] https://provider.healthybluenc.com/docs/gpp/NC_CAID_HEDISPrenatalandPostCareECDSCodingBulletin2023.pdf?v=202302031716.

[5] https://www.horizonblue.com/providers/resources/hedis-resources/hedis-measurement-year-my-2023-provider-tips-optimizing-hedis-results/prenatal-depression-screening-and-follow-pnd-e.

[6] https://www.ncqa.org/wp-content/uploads/2022/11/Special-Report-Nov-2022-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.

[7] https://www.ncqa.org/hedis/measures/prenatal-depression-screening-and-followup/.

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9842219/.

[9] https://saferbirth.org/wp-content/uploads/R2_AIM_Bundle_PMHC.pdf.

[10] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1117&context=son_dnp.

[11] https://www.prnewswire.com/news-releases/iehp-wins-innovation-award-for-integrating-physical-and-behavioral-health-across-the-public-healthcare-system-300549584.html.

[12] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2791528.

[13] https://www.hhs.texas.gov/reports/2022/10/maternal-depression-strategic-plan-update-fy21-25-fiscal-year-2022-update.

[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7238954/.

[15] https://www.ncqa.org/wp-content/uploads/2022/11/Special-Report-Nov-2022-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.

[16] https://www.ncqa.org/wp-content/uploads/2022/11/Special-Report-Nov-2022-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2026 CORE SETS

Measure Information	
Measure name	**Social Need Screening and Intervention**
Description	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: 1. **Food Screening.** The percentage of members who were screened for food insecurity 2. **Food Intervention.** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity 3. **Housing Screening**. The percentage of members who were screened for housing instability, homelessness, or housing inadequacy 4. **Housing Intervention.** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for housing instability, homelessness, or housing inadequacy 5. **Transportation Screening.** The percentage of members who were screened for transportation insecurity 6. **Transportation Intervention.** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for transportation insecurity
Measure steward	National Committee for Quality Assurance (NCQA)
Core Set domain	To be determined by CMS
Meaningful Measures area(s)	Equity
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Members of any age. Results are reported using the following age stratifications: • ≤ 17 years. • 18–64 years. • 65 and older. The total rate is the sum of the numerators for each age band divided by the sum of the denominators for each age band.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)
Denominator	The measure includes denominators for six rates: 1. **Denominator 1 – Food Screening.** Members of any age enrolled at the start of the measurement period who also meet criteria for participation.* 2. **Denominator 2 – Food Intervention.** All members in numerator 1 with a positive food insecurity screen finding between January 1 and December 1 of the measurement period. 3. **Denominator 3 – Housing Screening**. Members of any age enrolled at the start of the measurement period who also meet criteria for participation.* 4. **Denominator 4 – Housing Intervention.** All members in numerator 3 with a positive housing instability, homelessness, or housing inadequacy screen finding between January 1 and December 1 of the measurement period. 5. **Denominator 5 – Transportation Screening.** Members of any age enrolled at the start of the measurement period who also meet criteria for participation.* 6. **Denominator 6 – Transportation Intervention.** All members in numerator 5 with a positive transportation insecurity screen finding between January 1 and December 1 of the measurement period. * Participation is defined as the identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Participation includes both allocation and continuous enrollment: • Allocation criteria: The member was enrolled with a medical benefit throughout the measurement period (January 1 – December 31) and was enrolled on the last day of the measurement period. • Continuous enrollment criteria: See below.

Numerator	The measure includes numerators for six rates: 1. **Numerator 1 – Food Screening.** Members in denominator 1 with a documented result for food insecurity screening performed between January 1 and December 1 of the measurement period. 2. **Numerator 2 – Food Intervention.** Members in denominator 2 who received a food insecurity intervention on or up to 30 days after the date of the first positive food insecurity screen (31 days total). 3. **Numerator 3 – Housing Screening.** Members in denominator 3 with a documented result for housing instability, homelessness, or housing inadequacy screening performed between January 1 and December 1 of the measurement period. 4. **Numerator 4 – Housing Intervention.** Members 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 positive housing screen (31 days total). 5. **Numerator 5 – Transportation Screening.** Members in denominator 5 with a documented result for transportation insecurity screening performed between January 1 and December 1 of the measurement period. 6. **Numerator 6 – Transportation Intervention.** Members in denominator 6 who received a transportation insecurity intervention on or up to 30 days after the date of the first positive transportation screen (31 days total). **Screening numerator notes:** Screening numerators count only screenings completed using one of the instruments included in the measure specification (the list of eligible screening instruments is provided below). However, NCQA recognizes that organizations might need to adapt or modify instruments to meet the needs of their membership. • The measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators. • Tool developers have varying policies with regard to cultural adaptation and translations. NCQA urges organizations to refer to the tool developer for information about adaptations or translations that are available or allowed. • Only screenings documented using the LOINC codes in the measure specification count toward the measure's screening numerators (LOINC codes do not distinguish between original and adapted or translated instruments).

Numerator (continued)	Eligible screening instruments include: • Instruments that assess food, housing, and transportation insecurity: – Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool – American Academy of Family Physicians (AAFP) Social Needs Screening Tool – American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form – Health Leads Screening Panel®* – Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®* – WellRx Questionnaire • Food insecurity instruments: – Hunger Vital Sign™* (HVS) – Safe Environment for Every Kid (SEEK)®* – U.S. Household Food Security Survey (U.S. FSS) – U.S. Adult Food Security Survey (U.S. FSS) – U.S. Child Food Security Survey (U.S. FSS) – U.S. Household Food Security Survey–Six-Item Short Form (U.S. FSS) – We Care Survey • Housing instability and homelessness or housing inadequacy instruments: – Children's Health Watch Housing Stability Vital Signs™* – Norwalk Community Health Center Screening Tool (NCHC) – We Care Survey • Transportation insecurity instruments: – Comprehensive Universal Behavior Screen (CUBS) – Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 (CMS Assessment) – Outcome and assessment information set (OASIS) form—version E—Discharge from Agency (CMS Assessment) – Outcome and assessment information set (OASIS) form—version E—Resumption of Care (CMS Assessment) – Outcome and assessment information set (OASIS) form—version E—Start of Care (CMS Assessment) – PROMIS®* * Proprietary; may be cost or licensing requirement associated with use.

Numerator (continued)	**Intervention numerator notes:** The intervention must correspond to the type of need identified to count towards the numerator (e.g., a positive food insecurity screen finding must be met by a food insecurity intervention). Interventions may include any of the following categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.
Exclusions	All measure rates exclude the following populations: • Members who use hospice services or elect to use a hospice benefit any time during the measurement period. • Members who die any time during the measurement period. • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: – 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.
Continuous enrollment period	No more than one gap in enrollment of up to 45 days during the measurement period. For Medicaid members where enrollment is verified monthly, the member may not have a gap of more than 30 days.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2024 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The measure steward indicated that pilot testing of the measure was conducted on a national Medicaid sample (n=24,728) from one health plan in 2022. They indicated that during measure testing, performance for the screening rates was low, which was expected since it is a new measurement area. They did not identify differences in performance rates based on the data sources used, since the variety of data sources used for testing was limited. They noted that they plan to review first year measure results, for measurement year (MY) 2023, in summer 2024. New York Medicaid is using the measure with their managed care plans for MY 2023; data collection was in process at the time this measure information sheet was developed. Neither the measure steward nor the Workgroup member (WGM) who suggested the measure knew of additional states currently collecting or using the measure.

Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM indicated that data collection will be a challenge for state Medicaid and CHIP agencies. According to the materials provided by the measure steward when the measure was released for public comment,[1] some data elements needed to identify social needs may be more readily available than others, and some data sources may demonstrate greater accuracy than others. For example, they noted that documentation of social needs in claims data is increasing but remains uncommon. And while the Office of the National Coordinator for Health IT's certification criteria for Certified Electronic Health Record Systems requires that systems be able to collect structured information related to patient social, behavioral, and psychological data, there remains considerable variability in how patient social needs are screened for and documented in EHR systems. Further, this measure requires the use of LOINC codes, which has historically been a challenge for state reporting of other Core Set measures that use these codes.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that health-related social needs (HRSN) are associated with higher chronic disease prevalence and health care utilization. They indicated that understanding whether members identified at risk of health-related social needs are getting connected to needed services can help put other Core Set measure results into context.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM stated that the data source should allow for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language. HEDIS MY 2024 Vol. 2 contains general guidelines about how to categorize Medicaid members by race and ethnicity; however, the current technical specifications for the *Social Need Screening and Intervention* measure include only stratifications by age and product line. The measure steward indicated that they considered other stratification categories during measure testing, but determined that was not feasible, either because the denominators were too small to stratify, or the test data did not include the necessary data elements. They noted that they currently have different workstreams focused on developing standardized stratifications, such as race, ethnicity, sexual orientation and gender identity (SOGI), and disability. They have not established a timeline for adding these stratification categories to the measure specification.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM commented that Medicaid and CHIP populations may be at increased risk for health-related social needs.

Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM cited findings from the Accountable Health Communities (AHC) Model, available at: https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt-fg. The AHC Model tested whether connecting Medicare and Medicaid beneficiaries to community resources for their HRSNs improved health care utilization outcomes and reduced costs.
How measure can be used to monitor improvement	The WGM indicated that this would be a new area of measurement. According to the WGM, there is a lot of room for improvement and work needed to develop the pathways to report this measure.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM indicated that a national estimate is not available. They cited one study that found that 44.6 percent of HRSN screenings completed within a Medicaid Accountable Care Organization were positive for at least one social risk factor.[2]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward. The measure steward indicated that the latest Medicare Advantage advance notice included the measure in the category of "Potential New Measure Concepts and Methodological Enhancements for Future Years."[3]
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM acknowledged that data collection will be challenging for states. The measure steward noted that states would need to review their policies and contracts to confirm that providers are using one of the screening instruments in the measure specification. They also noted that 32 states have policies in place that require their managed care plans to screen enrollees for social needs; 16 states require incorporation of uniform questions within screening tools.[4] The measure steward also commented that state-level implementation of the measure would require health care settings to map appropriate screening tools and interventions to the terminology specified in the measure, and that states would likely need time for implementing these guidelines. The measure would also need to be implemented for Medicaid and CHIP fee-for-service populations using similar methodologies.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Other	NCQA, the measure steward, indicated that they are working to update the measure to add utility insecurity as a fourth domain. This update would go into effect for MY 2026. NCQA also indicated that they are building a new measure concept for social connection and plan to release that for public comment in 2024. The new measure will assess loneliness, inadequate social support, and social isolation in adults age 65 and older and will include the use of G and Z codes. They noted that public comment feedback around including these codes in the specification for social connection may influence the need for updates to the *Social Need Screening and Intervention* measure as well.

Citations

[1] https://www.ncqa.org/wp-content/uploads/2022/02/04.-SNS-E.pdf.
[2] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-08721-9.
[3] https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf.
[4] https://www.kff.org/other/state-indicator/states-reporting-social-determinant-of-health-related-policies-required-in-medicaid-managed-care-contracts/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.