Roundtable: Codes & Value-sets for the SDOH Screening and Referral Metric

June 14, 2024

Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure Technical Assistance (TA)

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

Welcome & Introductions

In the Zoom chat, please introduce yourself with the following:

- Your name & pronouns
- CCO affiliation
- Favorite board or video game

Please include your CCO in your Zoom name

We encourage you to have your cameras on, if possible, especially in the breakout groups

Roundtable Learning Objectives

- Understand existing and emerging social needs screening and referral-related codes and quality measures
- Share CCO approaches to coding and value-sets to date

SDOH Social Needs Screening & Referral Metric

Component 2

- Intended to measure the percentage of CCO members screened and referred to services.
- Beginning in 2025 CCOs will report on a sample of members who met continuous enrollment criteria.
- Hybrid model - multiple sources of data can be used including MIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources

Rate 1: % who were screened

Numerator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Denominator: All members who meet continuous enrollment criteria except those who decline to be screened in all 3 domains

Rate 2: % who screened positive

Numerator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

Denominator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Rate 3: % who screened positive and received a referral

Numerator: Members who received a referral within 15 calendar days for each domain in which they screened positive.

Denominator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

Level Setting- Medical Coding & Value Sets

- **Procedure Codes** Describe services or treatment a patient receives
  - Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS)
- **Diagnosis Codes** describe the diagnosis or issue that the treatment aims to address.
  - International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), Z codes, Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT), Logical Observation Identifiers Names and Codes (LOINC)
- **Value Sets** are a subset of codes of one or more code systems that share a common concept and use

All of these code vocabularies have codes associated with screening and referring a patient for food insecurity, housing insecurity, and transportation resources

National and Oregon Contexts

Contexts

National

- Social Needs Screening and Intervention (SNS-E) NCQA HEDIS
- Screening for the Social Drivers of Health (SDOH-1, SDOH-2) CMS
- Dual Eligible Special Needs Plans (D-SNP) Health Risk Assessment Screening
- Certified Community Behavioral Health Clinic Screening Measure
- Patient-centered medical home model (PCMH) screening component

Oregon

- CCO Incentive metric
- HRSN housing, nutrition and climate benefits
- Patient-centered primary care home model (PCPCH) screening component

SDOH Quality Measures

National Quality Measures: NCQA HEDIS Measure- SNS-E

	HEDIS SNS-E	Data Requirements
Screening	% of membership screened for food, housing, and transportation and were positive	LOINC Codes
Intervention	% of positive screens receiving intervention* within 30 days of first positive screen	CPT, SNOMED, HCPCS codes*

*interventions defined in Gravity Project Value Sets includes assistance, assessment, coordination, counseling, education, evaluation, referral, provision

https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Medicare- Screening for the Social Drivers of Health (SDOH-1, SDOH-2) CMS MIPS Measure

	MIPS SDOH 1 & 2	Data Requirements
Screening	SDOH-1: Percent of patients 18 years and older admitted to an inpatient hospital stay screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. SDOH-2: Rate 1 population screening positive	Numerator- Rate 1- Number of patients 18 and over screened using a standardized tool Rate 2- Number who screening positive Denominator- Number of admitted patients 18 years and over

https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Dual Eligible Special Needs Plans (D-SNP) Health Risk Assessment Screening

	D-SNP Measure	D-SNP Data Requirements
Screening	Initial and annual health risk assessments that include questions from approved instruments on housing, food, and transportation	Codes- screening instruments mapped to LOINC coding

https://www.cms.gov/files/document/r129mcm.pdf

Certified Community Behavioral Health Clinic Screening Measure

	CCBHC	Data Requirements
Screening	Percentage of individuals with any insurance over 18 who have been screened within the measurement year for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	Electronic health records (including billing records), paper health records, or a registry

https://www.cms.gov/files/document/r129mcm.pdf

NCQA Patient Centered Medical Homes (PCMH)

	PCMH KM 02 (Core) Comprehensive Health Assessment Requirements	PCMH data
Screening	• Screening for social determinants of health • Assessing population information • Identify and prioritize community resources needed by populations	• Documented process • Evidence of implementation
Referral	Referral to community organizations	• Documented process • Evidence of implementation

https://www.ncqa.org/wp-content/uploads/2020/07/20200727_NCQA_PCMH_Toolkit_for_Health_Centers.pdf

Oregon HRSN Benefit Codes

- **Codes for HRSN nutrition and housing services are not finalized**
- **Targeted case management for climate benefit- procedure code T1017**
  - Includes outreach and engagement by CBO or HRSN provider, including:
    - Contacting and engaging members who belong to one or more HRSN covered populations
    - Determining whether they are enrolled in FFS or a CCO, and which one
    - Transmitting to CCO partial or complete HRSN Request Form or information for eligibility determination and service authorization
    - Providing HRSN eligible members who may have a need for medical, peer, social, educational, legal, or other related services with information and logistical support necessary to connect them with the needed resource and services

https://www.oregon.gov/oha/HSD/OHP/CCO/HRSN-Guidance-Document.pdf

Patient-centered Primary Care Home Program (PCPCH) (Oregon)

- PCPCH recognition criteria changing in January 2025

	PCPCH	PCPCH Data Requirements
Screening	**3.D.2. (10 points):** Routinely screens or assesses entire patient population for at least 3 HRSN and refers patients with positive screens to community resources.	• Screening policy, procedure or workflow • Screening tool used • Documentation of referral process to community-based organizations or resources
Referral	**3.D.3. (15 points):** Routinely screens and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly. • analyzes data to identify target populations or most prevalent HRSNs • engages in population-based interventions (direct services, community partnership, referral to HRSN organizations and tracking results)	• Screening policy, procedure or workflow • Screening tool used • Data on HRSN prevalence • Documentation of population-based intervention

CCO Approaches to SDOH Codes

CCO Sharing- Pre-Session Survey (N=11)

Approximately what proportion of your contracted providers are currently sending Z-codes or other codes to represent social needs screening and/or referral?

- 0% or very few are using Z code. (6 CCOs)
- 12-13% are using Z codes (3 CCOs)
- 20% are using Z codes or similar codes
- 60% of our provider network have utilized Z-codes

CCO Sharing- Pre-Session Survey (N=11)

Would it be helpful to CCOs if OHA required a certain set of codes or value-set for the metric?

Yes (7)

- For consistency and benchmarking (1)
- For alignment across CCOs and easing burden on providers/clinics. Would prefer NCQA SNS-E measure coding (1)
- So we can set up specific value-based payment arrangements to improve capacity for clinics and CBOs (1)
- So we can align with national standards i.e. HEDIS and the Gravity Project (1)

Maybe (4)

- It might be helpful as long as there's still flexibility for CCOs in how we collect this info and report to OHA (4)

CCO Sharing- Pre-Session Survey (N=11)

Has your CCO recommended codes to your providers for the metric?

Yes/No	If so which ones?
Yes (5)	• 1 CCO has a clinic-facing document with LOINC, SNOMED, ICD10 and Z-codes • 4 CCOs have shared a clinic-facing document with a subset of HEDIS SNS-E codes
No (6)	• 1 CCO wants to align with HEDIS SNS-E • 1 CCO want standardized reporting templates that align with national standards

CCO Approaches to SDOH Codes

Therese McIntyre, MPH
Senior Quality & Risk Innovation Strategist,
PacificSource Health Plans

Breakout Discussion

You will be randomly assigned to a breakout room. In your breakout rooms, you will have 15 minutes to discuss:

How is your CCO approaching coding and value-sets for the metric?

- **How are you planning to encourage or support health care providers to use codes for the metric?**
- **Are there particular national or state value-sets or documentation requirements that you would like to see your providers align with? Which ones and why?**

Next Steps

★ Attend Roundtable Session II on June 18, 3pm PST on **Engaging providers in claims-based reporting**

★ **Check out the 2024 CCO Learning Collaborative Playbook!**

Homework...

- Reach out to TA providers with questions
- Connect with each other
- Prepare to share your thoughts and strategies for engaging providers on June 18th

Measure Contacts

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