Social Determinants of Health (SDoH) Screening and Intervention

Implementation and Measurement Challenges and Barriers

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SDoH Screening and Intervention Current Landscape

- The Centers for Medicare & Medicaid Services (CMS) Framework for Health Equity 2022-2032 prioritizes addressing health disparities and improving health equity through the collection, reporting, and analysis of standardized demographic and SDoH data.[1]

- While the collection of SDoH-related patient data and clinical outcomes has been identified as a need for the development of policy and programs to support improved health outcomes, adoption of standardized screening and intervention data collection methods through code systems and standardized screening tools continues to be administratively burdensome for providers and practices.[1]

- To reduce FY2026 documentation and reporting burden of SDoH data collection, CMS OPPS CY26 Final Rule has removed the "Screening for Social Drivers of Health" and "Screen Positive Rate" measures from Hospital Inpatient, Outpatient, and Ambulatory Surgical Centers quality reporting.[2]

- CMS plans to continue to strengthen the use of SDoH data through risk adjustment activity for high-risk patients.[2]

Kentucky primary care providers report the same documentation and reporting burden for SDoH data collection at the point of care.

A deeper look at the current reporting burden

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How we are currently measuring and reporting

Social Need Screening and Intervention (SNS-E) NCQA HEDIS® Measurement*
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.

NCQA Measurement Changes for 2026
The percentage of persons who were screened using prespecified instruments, or were assessed by a provider, for unmet food, housing and transportation needs at least once during the measurement period, and the percentage of persons with a positive screen or identified need for food, housing or transportation who received an intervention corresponding to the positive screen or identified need within 30 days.[3]

Addition of:
- Screening G-code for ease of reporting by standardized screening tool
- Additional ICD-10 Z-codes for intervention denominator identification

Why the 2026 changes? To ease the burden of reporting for the provider/practice.
What are the primary care practice reporting requirements and related challenges and barriers for SDoH under this revised measurement.

**Specification also utilized by KY DMS Value-Based Program*

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Reporting Requirements and Practice Challenges and Barriers

REPORTING REQUIREMENT	PRACTICE CHALLENGES and BARRIERS
Utilization of a validated, standardized instrument, such as PRAPARE or CMS ACH	1 Survey tool licensing, if applicable 2 Significant financial and expertise investment in technology data management systems and EHR for: • Standardized screening tool 'build' • Intervention documentation templates • LOINC, SNOMED, CPT backend set up • Electronic file feeds for reporting 3 Practice workflow design and implementation for new process and procedure 4 Practice provider and personnel education and training for workflow, documentation, coding (HCPCS and ICD-10), and billing adoption 5 Potential for positive screening but lack of intervention resource to address the risk or need
NCQA HEDIS® Electronic Clinical Data Systems (ECDS) required screening reporting with LOINC codes or new 2026 HCPCS G-code only[4] (may not be accepted by all lines of business)	
ICD-10-CM New Z-Codes reporting positive screening specific to identified risk	
Intervention documentation and required (SNOMED CT) or Current Procedural Terminology (CPT) codes for intervention delivered	

Additional Current Environment

1 Some Kentucky primary care providers are/are not currently performing the screenings
2 Some payors are working to collect SDoH screening and intervention data outside of the provider/patient encounter
3 Variability in approach to collect SDoH data has likely increased costs (time, fees) involved

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References:

1 CMS Framework for Health Equity 2022–2032;
Strategies to Help Care Settings Face Barriers to SDOH Screenings

2 CMS removes SDoH reporting in OPPS CY 26 Final rule
CMS removes SDoH reporting in OPPS CY 26 Final rule – MedLearn Publishing

3 Social Needs Screening and Intervention (SNS-E): Measure Updates for HEDIS MY2026 and Frequently Asked Questions;
NCQA-2025-SocialNeeds-ScreeningIntervention-FAQs-WEB.pdf

4 Using HCPCS Code G0136 for Social Determinants of Health Risk Assessment;
G0136 for SDOH | AAFP

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