From: Erin Martens
To: HRSA Paperwork
Subject: [EXTERNAL] UDS Public Comment - SUD-I and SUD-E
Date: Wednesday, February 4, 2026 12:35:35 PM
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This comment is related to the new SUD measures for 2025: initiation and engagement in treatment.

I would like to recommend that the UDS measure specifications be reviewed to consider diverting from the eCQM provided through HEDIS. This measure since it was originally designed by HEDIS was designed to be a measure that looks comprehensively **at health information retained by an insurance payor, which includes claims and prescription information from across the healthcare system**, not information limited to a single primary care healthcare organization. Because of this, this measure artificially deflates the performance of health centers related to this measure in the following ways:

1. **Over-identifying existing SUD episodes in treatment as new SUD episodes**. Because health centers are unable to report on prescription fill data, the measure spec that defines a "New Episode" of SUD as any care related to a SUD diagnosis where there was no care related to the diagnosis in the 60 days prior is incorrectly identifying patients with known SUD and established SUD treatment as "new episodes". Since these patients do not in fact have a NEW episode, our processes will not align with the initiation and treatment expectations necessarily, since the patient is already regularly taking a prescription, and may only be receiving a visit with their prescribing provider every 90 days. This artificially inflates the denominator of both SUD-I and SUD-E, and deflates numerator performance of both.
2. **Failing to capture qualifying SUD care occurring outside the health center.** The eCQM specs clearly note that inpatient and intensive outpatient services for SUD are qualifying initiation and engagement interventions, and a payor would have claims data reflecting this care. Health Centers, however, do not have a mechanism in the eCQM specs by which to document that we are aware of such qualifying services occurring outside of our health centers. There should be a clear path for health centers to report this qualifying outside care even if it is patient-reported.
3. **Failing to include some CPT codes for integrated behavioral health services that may be offered at FQHCs.** While FQHCs generally are not equipped to provide psychiatry, many have integrated BH services and offer individual counseling and similar services for support of patients with SUD. These CPT codes should be added as qualifying interventions, most importantly CPT-90791.

In seeking to accurately report this measure for 2025 we have consistently found that our performance per the measure specs does not accurately reflect our actual performance in initiating and engaging our patients in treatment for SUD, and we know that HRSA's goal with these measures is to understand the scope of care occurring in health centers. I believe that the limitations of this measure harm HRSA's understanding of the ways health centers are seeking to engage patients with SUD in care and treatment.

Thanks for your consideration,
Erin Martens

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