



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 3175

Corresponding Measures:

De.2. Measure Title: Continuity of Pharmacotherapy for Opioid Use Disorder

Co.1.1. Measure Steward: University of Southern California

De.3. Brief Description of Measure: Percentage of adults of at least 18 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

1b.1. Developer Rationale: The rapidly rising number of deaths and near-deaths from opioid overdoses over the past several years has brought the issue of treating opioid use disorder (OUD) to the forefront of the policy agenda. The Surgeon General, who mailed a call to action to 2.3 million doctors, nurses, dentists, and other clinicians asking them to help address this escalating epidemic (Murthy, 2016), and the governors of many states have prioritized improving access to prevention and treatment of OUD.

The high prevalence of OUD has increased the sense of urgency: According to the 2014 National Survey on Drug Use and Health (NSDUH), 1.7 million adults 18 years and older were classified as having a pain reliever use disorder and 886,000 adults had used heroin in the past year (SAMHSA, 2015). In 2014, there were 489,532 episodes for OUD treatment, including outpatient treatment, detoxification, and residential treatment, in the Treatment Episode Data Set (TEDS) (SAMHSA, 2016).

Medication-assisted treatment (i.e., pharmacotherapy combined with counseling) is an evidence-based and effective treatment option for patients with OUD. Individuals with OUD receiving pharmacotherapy have significantly lower rates of mortality while they continue to receive medication, compared to individuals who were not receiving medication (Brugal et al., 2005; Cornish et al., 2010; Cousins et al., 2016; Davoli et al., 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). But OUD medications remain markedly underutilized (Volkow et al., 2014). Of the almost half million aforementioned episodes, medication-assisted treatment was planned for only 25.4 percent (20.7 percent in outpatient treatment, 3.6 percent in detoxification, and 1.1 percent in residential treatment) (SAMHSA, 2016).

Additionally, ensuring treatment continuity is critical to the success of medication-assisted treatment. Longer treatment duration for individuals with OUD is associated with better outcomes and the best outcomes have been observed in patients in long-term methadone maintenance programs ("Effective medical treatment of opiate addiction", 1998; Moos et al., 1999; NIDA 1999; Ouimette et al., 1998; Peles et al., 2013).

In addition, there is strong evidence for increased mortality when individuals with OUD transition off pharmacotherapy, both in the short term (within the first 0-4 weeks after discontinuing pharmacotherapy) and over the long term (Cornish et al., 2010; Cousins et al., 2016; Davoli et al., 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016).

Therefore, the proposed measure focuses on continuity of pharmacotherapy, defined as treatment duration of at least 180 days and absence of treatment gaps of greater than seven days. Several important benefits related to quality improvement are envisioned with the implementation of this measure. First, the measure will help health plans and providers to identify individuals with OUD who are non-adherent to or discontinue pharmacotherapy. As a result, this measure will encourage health plans and providers to develop communication and education tools and processes to improve treatment continuity in their patients with OUD. Improved treatment continuity is expected to result in lower rates of relapse, and less substance use-related morbidity and mortality. Adoption of this performance measure has the potential to improve quality of care for individuals with OUD and, therefore, advance quality of care by engaging patients as partners in their care, and promoting effective communication and coordination of care, priority areas identified in the National Quality Strategy. The measure aligns with to the primary and secondary Meaningful Measure

Areas of “Prevention and Treatment of Opioid and Substance Use Disorders and “Preventable Healthcare Harm”, respectively.

CITATIONS

Brugal MT, Domingo-Salvany A, Puig R, et al. Evaluating the impact of methadone maintenance programmes on mortality due to overdose and aids in a cohort of heroin users in Spain. *Addiction*. 2005;100(7):981-989.

Cornish R, Macleod J, Strang J, Vickerman P, Hickman M. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. *BMJ*. 2010;341:c5475.

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Davoli M, Bargagli AM, Perucci CA, et al. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multisite prospective cohort study. *Addiction*. 2007;102:1954-9.

Degenhardt L, Randall D, Hall W, Law M, Butler T, Burns L. Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: risk factors and lives saved. *Drug and alcohol dependence*. 2009;105:9-15.

Effective medical treatment of opiate addiction. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. *JAMA*. 1998;280:1936-1943.

Gibson AE, Degenhardt LJ. Mortality related to pharmacotherapies for opioid dependence: a comparative analysis of coronial records. *Drug Alcohol Rev*. 2007; 26(4), 405-410.

Moos RH, Finney JW, Ouimette PC, Suchinsky RT. A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. *Alcohol Clin Exp Res*. 1999;23(3):529-36.

Murthy VH. Ending the Opioid Epidemic - A Call to Action. *N Engl J Med*. 2016 Dec 22;375(25):2413-2415. doi: 10.1056/NEJMp1612578. Epub 2016 Nov 9.

National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. NIH Publication No. 99–4180. Rockville, MD: NIDA, 1999, reprinted 2000.

Ouimette PC, Moos RH, Finney JW. Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. *J Stud Alcohol*. 1998;59:513-522.

Peles E, Schreiber S, Adelson M. Opiate-dependent patients on a waiting list for methadone maintenance treatment are at high risk for mortality until treatment entry. *J Addict Med*. 2013;7(3):177-82.

Pierce M, Bird SM, Hickman M, Marsden J, Dunn G, Jones A, et al. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. *Addiction*. 2016;111:298-308.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: results from the 2014 National Survey on Drug Use and Health. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015: 7-12 (<http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>).

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016). Treatment Episode Data Set (TEDS): 2004-2014. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-84, HHS Publication No. (SMA) 16-4986. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at http://www.samhsa.gov/data/sites/default/files/2014_Treatment_Episode_Data_Set_National_Admissions_9_19_16.pdf

Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies--tackling the opioid-overdose epidemic. *N Engl J Med*. 2014 May 29;370(22):2063-6

S.4. Numerator Statement: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days S.6. Denominator Statement: Individuals at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication S.8. Denominator Exclusions: There are no denominator exclusions.
De.1. Measure Type: Process S.17. Data Source: Claims S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Population : Regional and State
IF Endorsement Maintenance – Original Endorsement Date: Jun 28, 2017 Most Recent Endorsement Date: Nov 20, 2020
IF this measure is included in a composite, NQF Composite#/title: IF this measure is paired/grouped, NQF#/title: De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A, not a paired measure

1. Evidence, Performance Gap, Priority – Importance to Measure and Report
Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. <i>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</i>
1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form NQF_3175_OUD_Evidence_Form_1-5-21-637453878356014591.docx, NQF_3175_OUD_Evidence_Form_updated-637540190364604172.docx 1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission? Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence. Yes
1b. Performance Gap Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating: - considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or - Disparities in care across population groups. 1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure) <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i> The rapidly rising number of deaths and near-deaths from opioid overdoses over the past several years has brought the issue of treating opioid use disorder (OUD) to the forefront of the policy agenda. The Surgeon General, who mailed a call to action to 2.3 million doctors, nurses, dentists, and other clinicians asking them to help address this escalating epidemic (Murthy, 2016), and the governors of many states have prioritized improving access to prevention and treatment of OUD. The high prevalence of OUD has increased the sense of urgency: According to the 2014 National Survey on Drug Use and Health (NSDUH), 1.7 million adults 18 years and older were classified as having a pain reliever use disorder and 886,000 adults had used heroin in the past year (SAMHSA, 2015). In 2014, there were 489,532 episodes for OUD treatment, including outpatient treatment, detoxification, and residential treatment, in the Treatment Episode Data Set (TEDS) (SAMHSA, 2016). Medication-assisted treatment (i.e., pharmacotherapy combined with counseling) is an evidence-based and effective treatment option for patients with OUD. Individuals with OUD receiving pharmacotherapy have significantly lower rates of mortality while they continue to receive medication, compared to individuals who were not receiving medication (Brugal et al., 2005; Cornish et al., 2010; Cousins et al., 2016; Davoli et al., 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). But OUD

medications remain markedly underutilized (Volkow et al., 2014). Of the almost half million aforementioned episodes, medication-assisted treatment was planned for only 25.4 percent (20.7 percent in outpatient treatment, 3.6 percent in detoxification, and 1.1 percent in residential treatment) (SAMHSA, 2016).

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Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016). Treatment Episode Data Set (TEDS): 2004-2014. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-84, HHS Publication No. (SMA) 16-4986. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at http://www.samhsa.gov/data/sites/default/files/2014_Treatment_Episode_Data_Set_National_Admissions_9_19_16.pdf

Volkow ND, Frieden TR, Hyde PS, Cha SS. Medication-assisted therapies--tackling the opioid-overdose epidemic. *N Engl J Med*. 2014 May 29;370(22):2063-6

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (*This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.*) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The measure scores are calculated based on claims data for two-year rolling periods for 2010-2015 (commercial claims) and 2013-2016 (Medicare claims). Tables 1-3 present results for commercial claims and Tables 4-6 present results for Medicare claims.

The overall measure score results for the commercial data are shown in Table 1. The results by state and health plan are shown in Tables 2 and 3, respectively. The number of episodes in the denominator of the measure ranged from a low of 17,229 in 2010-2011 to a high of 43,812 in 2013-2014 (Table 1). Over the period from 2010-2015, measure scores increased from 0.245 to 0.305.

Over the 2010-2015 period, the number of states with at least 20 individuals eligible for the denominator increased from 44 states in 2010-2011 to 47 states in 2012-2013 (Table 2). Over the 2010-2015 period, the number of health plans with at least 20 individuals eligible for the denominator increased from 88 health plans in 2010-2011 to 290 health plans in 2013-2014 (Table 3).

Table 1. Denominator, Numerator, and Measure Score for Two-Year Rolling Periods, 2010-2015, commercial claims

Time Period / Denominator / Numerator / Score

2010-2011 / 17,229 / 4,225 / 0.245

2011-2012 / 34,879 / 8,121 / 0.233

2012-2013 / 41,867 / 11,462 / 0.274

2013-2014 / 43,812 / 12,380 / 0.283

2014-2015 / 40,379 / 12,290 / 0.305

Table 2. Summary Statistics for Measure Scores by State, Two-Year Rolling Periods, 2010-2015

Time Period / Number of States / Mean / Median / Min / Max / STD / IQR / P10 / P25 / P50 / P75 / P90

2010-2011 / 44 / 0.250 / 0.231 / 0.034 / 0.542 / 0.086 / 0.112 / 0.169 / 0.188 / 0.231 / 0.300 / 0.333

2011-2012 / 47 / 0.246 / 0.242 / 0.115 / 0.378 / 0.066 / 0.105 / 0.169 / 0.189 / 0.242 / 0.294 / 0.342

2012-2013 / 47 / 0.286 / 0.283 / 0.152 / 0.434 / 0.072 / 0.116 / 0.189 / 0.229 / 0.283 / 0.345 / 0.387

2013-2014 / 46 / 0.287 / 0.280 / 0.149 / 0.455 / 0.076 / 0.114 / 0.199 / 0.235 / 0.280 / 0.349 / 0.394

2014-2015 / 46 / 0.307 / 0.308 / 0.195 / 0.505 / 0.071 / 0.093 / 0.218 / 0.256 / 0.308 / 0.348 / 0.395

Table 3. Summary Statistics for Measure Scores by Health Plan, Two-Year Rolling Periods, 2010-2015

Time Period	N of Health Plans	Mean	Median	Min	Max	STD	IQR	P10	P25	P50	P75	P90
2010-2011	88	0.225	0.198	0.034	0.571	0.109	0.140	0.100	0.152	0.198	0.292	0.396
2011-2012	201	0.208	0.200	0.033	0.500	0.088	0.112	0.100	0.145	0.200	0.258	0.333
2012-2013	279	0.245	0.238	0.000	0.550	0.105	0.143	0.122	0.167	0.238	0.310	0.382
2013-2014	290	0.254	0.241	0.045	0.600	0.095	0.129	0.138	0.187	0.241	0.316	0.381
2014-2015	264	0.277	0.263	0.025	0.652	0.103	0.137	0.162	0.202	0.263	0.339	0.409

STD=standard deviation; IQR=interquartile range; PNN=NNth percentile

The overall measure score results for the Medicare data are shown in Table 4. The results at the clinician and clinician-group levels are shown in Tables 5 and 6, respectively. The number of episodes in the denominator of the measure ranged from a low of 50,997 in 2013-2014 to a high of 70,947 in 2015-2016 (Table 1). Over the period from 2013-2016, measure scores increased from 0.259 to 0.296.

Table 4. Denominator, Numerator, and Measure Score for Two-Year Rolling Periods, 2013-2016, Medicare data

Time Period	Denominator	Numerator	Score
2013-2014	50,997	13,222	0.259
2014-2015	61,238	16,803	0.274
2015-2016	70,947	21,024	0.296

Over the 2013-2016 period, the number of clinicians with at least 25 individuals eligible for the denominator increased from 229 in 2013-2014 to 287 in 2015-2016 (Table 5). Over the 2013-2016 period, the number of clinician-groups/practices with at least 25 individuals eligible for the denominator increased from 326 in 2013-2014 to 490 in 2015-2016 (Table 6).

Table 5. Summary Statistics for Measure Scores by Clinician, Two-Year Rolling Periods, 2013-2016

Time Period	N of Providers	Mean	Median	Min	Max	STD	IQR	P10	P25	P50	P75	P90
2013-2014	229	37.77	32	25	146	18.04	14	26	27	32	41	55
2014-2015	251	40.41	31	25	194	24.15	17	25	27	31	44	62
2015-2016	287	40.96	32	25	241	24.59	18	26	27	32	45	68

Table 6. Summary Statistics for Measure Scores by Clinician-group/Practice, Two-Year Rolling Periods, 2013-2016

Time Period	N of Practices	Mean	Median	Min	Max	STD	IQR	P10	P25	P50	P75	P90
2013-2014	326	50.11	37	25	285	37.42	23	26	29	37	52	85
2014-2015	386	53.10	40	25	496	48.89	26	26	29	40	55	87
2015-2016	490	51.90	37	25	423	42.68	24	27	30	37	54	89

STD=standard deviation; IQR=interquartile range; PNN=NNth percentile

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Data from the testing of the measure as specified are provided in 1b.2 above.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe*

the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The measure was stratified for disparities by age, gender, race/ethnicity and dual eligibility status. The results/scores for 2015-2016 are presented for these categories in Table 7. The measure scores were lowest in individuals > 85 years of age and highest in individuals < 65 years of age. Scores were higher for males than females, for white patients higher than for all others and for dually-eligible beneficiaries higher than for non dually-eligible ones.

Table 7. Measure Scores by Age, Gender, Race/ethnicity and Dual Eligibility Status for Medicare Sample, 2015-2016

Category / Denominator / Numerator / Measure Score

Age

< 65 years / 58,975 / 18,261 / 0.310

65 –74 / 9,415 / 2,344 / 0.249

75 –84 / 2,044 / 339 / 0.166

> 85 years / 513 / 80 / 0.156

Gender

Both Genders / 70,947 / 21,024 / 0.296

Female / 36,150 / 10,331 / 0.268

Male / 34,797 / 10,693 / 0.307

Race/ethnicity

White / 58,645 / 17,901 / 0.305

Black / 6,241 / 1,448 / 0.232

Hispanic / 4,214 / 1,181 / 0.280

Other / 1,847 / 494 / 0.267

Dual eligibility

No / 21,750 / 5,466 / 0.251

Yes / 49,197 / 15,558 / 0.316

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Data on disparities from the testing of the measure as specified are provided in 1b.4 above.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

N/A

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment: [NQF_3175_OUD_Code_Lists_2019_version-637328210442709870-637453773523898129.xlsx](#)

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [NQF_3175_OUD_Code_Lists_2021_version.xlsx](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Codes updated to 2021 lists. No material changes.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The measure numerator is calculated based on claims data for rolling two-year periods. The measure numerator is defined as individuals in the denominator with at least 180 days of “continuous pharmacotherapy” with an OUD medication.

Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days’ supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days’ supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days’ supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If two or more prescription

claims occur on the same day or overlap, the surplus based on the days' supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable/implantable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day's supply for the injectable/implantable or office-dispensed medication is not retained.

An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days' supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended-release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

Justification of Measure Definition: We define treatment continuity as (1) receiving at least 180 days of treatment and (2) no gaps in medication use of more than 7 days.

Our definition of minimum duration is based on the fact that the FDA registration trials for OUD drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb, undated), and we have no evidence for effectiveness of shorter durations. In addition, several recommendations support a minimum six-month treatment period as the risk of relapse is the highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb, undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes compared to shorter treatments and the best outcomes have been observed among patients in long-term methadone maintenance programs ("Effective medical treatment of opiate addiction", 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We did not specify a maximum duration of treatment, as no upper limit for duration of treatment has been empirically established (US DHHS, 2015).

We opted for using a treatment gap of more than seven days in our definition, given that the measure includes three active ingredients with different pharmacological profiles. There is substantial evidence for an elevated mortality risk immediately after treatment cessation (Cornish et al., 2010; Cousins et al., 2016; Davoli et al., 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends reevaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; "Drug Misuse and Dependence—Guidelines on Clinical Management", 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation.

Citations

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S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

Individuals at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The measure denominator is calculated for rolling two-year periods. The denominator includes individuals of at least 18 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period.

The diagnosis codes used to identify individuals with OUD included:

- ICD-9: 304.0x, 305.5x
- ICD-10: F11.xxx

These codes and descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

There are no denominator exclusions.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

There are no denominator exclusions.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

Measure results may be stratified by:

- Age
- Gender
- Race/ethnicity
- Dual eligibility status

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

The measure score is calculated for rolling two-year periods.

DENOMINATOR: Individuals of at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

CREATE DENOMINATOR:

1. For each two-year period, identify individuals who are at least 18 years of age for the duration of the first year during which they appear in the period.

2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called "ICD-9 Diagnosis Codes" and "ICD-10 Diagnosis Codes" in the Excel file called "NQF 3175 OUD Code Lists", which is attached to this form under Item S.2b.

3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-year period with a date at least 180 days before the end of the final calendar year of the measurement period:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

Or a HCPCS code for any of the following OUD medications:

- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

Claims for oral medications with negative, missing, or zero days' supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists," which is attached to this form under Item S.2b.

4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator.

NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

CREATE NUMERATOR:

For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method:

1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of:

- The date on which the individual exhausts their days' supply, including any pre-existing surplus, following their final claim (assuming daily use).
- The individual's death date.
- December 31st of the second year in the two-year period.

2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days' supply.

2a. Sort OUD medication claims by individual's ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days' supply from other prior or same-day fills.

2b. Naltrexone and buprenorphine injections contribute 30 days' supply and a buprenorphine implant 180 days unless another claim is found sooner, in which case the injection or implant covers only the days up to the next claim.

2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575).

2d. Claims for injections/implants and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted.

2e. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days' supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing.

4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator.

CALCULATE MEASURE SCORE:

1. Calculate the measure score by dividing the numerator by the denominator.

2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator.

3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator.

4. Calculate the measure score for each clinician and clinician-group/practice level. Attribute individuals to clinicians and clinician-groups/practices based on the plurality of treatment days covered. Clinicians are identified based on their National Provider Identifier and clinician-groups/practices based on their Tax Identification Number. The measure score is reported for clinicians and clinician-group/practices with at least 25 denominator-eligible patients attributed to them. Details of the attribution method and its empirical justification are described in the attached Attribution Analysis document

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
Not applicable; this measure does not use a sample or survey.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

Not applicable; this measure does not use a sample or survey.

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

For measure calculation, the following files from the Truven MarketScan® Commercial Database and the Medicare 100% Research Identifiable Files (RIF) were used:

- Enrollment data
- Drug claims/prescription drug events
- Medical claims

We used data from these files for calendar years 2010-2016. The MarketScan database has long been a commonly used data source to study patterns of commercially insured patients. The Medicare RIF files contain all claims for beneficiaries in traditional Medicare. Both databases contain fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure's eligibility criteria.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual, Health Plan, Population : Regional and State

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

NQF3175_testing_attachment_Jan_2021.docx, NQF3175_testing_attachment_April_2021-637540031294570800.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not

prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic claims

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

Not applicable because all data elements necessary to compute the measure scores are derived from electronic claims.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

The measure is in operational use. We provide technical assistance to users and have not received reports about feasibility issues. Testing demonstrated that the measure was feasible to specify and calculate using administrative claims data. The claims data needed to implement the measure are available, accessible, and timely. Issues affecting feasibility regarding missing data were not identified. The cost of data collection is negligible, since the administrative data (collected primarily for billing purposes) are used as the data source for this measure. No other feasibility/implementation issues were identified.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

There are no fees, licensing, or other requirements to use any aspect of the measure as specified.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Payment Program Public Reporting and Payment Program (MIPS) – ID 468 https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019&measureType=Process&specialtyMeasureSet=Mental%2FBehavioral%20Health Medicaid 1115 Substance Use Disorder Demonstrations https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/substance-use-disorders/1115-substance-use-disorder-demonstrations/index.html Regulatory and Accreditation Programs https://files.nc.gov/ncdma/documents/NC-Medicaid-Managed-Care-Quality-Measurement-Technical-Specifications-Public.pdf North Carolina Medicaid

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting
- Name of program and sponsor: Quality Payment Program - CMS
- Purpose: Quality measure used in the Merit-based Incentive Payment System (ID 468)
- Geographic area and number and percentage of accountable entities and patients included: National program, no data on reporting available yet.
- Level of measurement and setting: Clinician and clinician-group/practice level
- Name of program and sponsor: Medicaid 1115 Substance Use Disorder Demonstrations
- Purpose: New payment and delivery models for substance use care in Medicaid
- Geographic area and number and percentage of accountable entities and patients included: 21 states approved.
- Level of measurement and setting: State
- Name of program and sponsor: North Carolina's Transformation to Medicaid Managed Care
- Purpose: Accountability program for Medicaid Managed Care
- Geographic area and number and percentage of accountable entities and patients included: data not yet available.
- Level of measurement and setting: health plan

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

Implementation is too recent (mostly starting in CY 2019) to have information back from measured entities.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Implementation is too recent (mostly starting in CY 2019) to have information back from measured entities.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Implementation is too recent (mostly starting in CY 2019) to have information back from measured entities.

4a2.2.2. Summarize the feedback obtained from those being measured.

Implementation is too recent (mostly starting in CY 2019) to have information back from measured entities.

4a2.2.3. Summarize the feedback obtained from other users

We maintain a hotline for measure users to ask technical questions. Requests received thus far pertained to clarifications on how to implement certain definitions. No fundamental problems with the construct or the operational definitions were reported.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Implementation is too recent (mostly starting in CY 2019) to have information back from measured entities.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Both the commercial and the Medicare data show improvement in scores over time and also a steady increase in the size of the denominator, suggesting that pharmacotherapy for OUD is becoming more common and continuity of care improve.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

None reported

4b2.2. Please explain any unexpected benefits from implementation of this measure.

None reported

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

1664 : SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

The target population of the proposed measure is related to the two measures listed above (NQF 0004 and NQF 1664). Differences among the three measures, along with the rationale and impact, are discussed below in the text box for Item 5b.1. The text box for this item (5a.2) would not accommodate the length of our response.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

There are no competing measures that address both the same measure focus and the same target population as the proposed measure.

RESPONSE TO ITEM 5A.2

The information below is the response to Item 5a.2, describing the differences, rationale, and impact on interpretability and data collection burden for the two NQF-endorsed RELATED measures which were identified. (We have inserted it here because the text box under Item 5a.2 would not accept this volume of formatted text.)

The target population of the proposed measure is related to the two NQF-endorsed measures listed above (NQF 0004 and NQF 1664). The proposed measure focuses on continuity of pharmacotherapy for patients with OUD. NQF 0004 focuses on treatment initiation and engagement of patients with a new episode of OUD or other substance use disorders, including alcohol use disorder (AUD). NQF 1664 focuses on OUD and other drug use disorders among hospital discharges. Differences among the three measures, along with the rationale and impact are discussed below.

Diagnoses Included in Denominator Definition

- Proposed measure: Diagnosis of OUD
- NQF 0004: Diagnosis of alcohol or other drug dependence
- NQF 1664: Diagnosis of AUD or another substance use disorder
- Rationale and impact of focusing on only OUD: There are different medications for treatment of OUD and AUD, and there are no FDA-approved medications for treatment of other substance use disorders. In addition, the conceptual issues related to continuity of pharmacotherapy differ between OUD and AUD, so developing separate measures for the two disorders is required. The impact of this is a more narrowly focused measure that provides information specific to individuals with OUD.

Age Range

- Proposed measure: Patients at least 18 years of age
- NQF 0004: Patients aged 13 years of age and older
- NQF 1664: Patients 18 years of age and older
- Rationale and impact of limiting to individuals 18 years of age and older: Medications for treatment of OUD have not been approved by the FDA for adolescent patients 13-17 years of age; therefore, the proposed measure is restricted to adults of at least 18 years of age.

Data Source

- Proposed measure: Electronic claims data
- NQF 0004: Administrative claims, electronic clinical data
- NQF 1664: Electronic clinical data, paper medical records
- Rationale and impact of using electronic claims data: Electronic claims data are timely, accessible, and relatively inexpensive to use for analyses of a large number of patients. Using a single source of data expedites the calculation of the measure, and will provide feedback to providers sooner.

Inpatient vs. Outpatient

- Proposed measure: Inpatient and outpatient
- NQF 0004: Inpatient and outpatient
- NQF 1664: Inpatient discharges
- Rationale and impact of using inpatient and outpatient records to identify patients: A large majority of patients with OUD are not admitted to a hospital, so using inpatient and outpatient data leads to more complete identification of the population eligible for treatment.

Process of Care Included in Numerator Definition

- Proposed measure: Continuity of pharmacotherapy for OUD
- NQF 0004: Inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization for adults with a new episode of AUD, OUD, or other substance use disorders
- NQF 1664: Medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment
- Rationale and impact of the process of care included in the numerator definition: Successful pharmacotherapy of OUD requires continuity over at least a 180-day period. Therefore, providing feedback to providers about continuity of OUD pharmacotherapy has the potential to improve continuity rates by increasing provider awareness, and motivating health plans and insurers to develop educational material and programs about pharmacotherapy for OUD for both providers and patients.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment **Attachment:** [attribution_analysis_results_NPI_and_TIN_102919_revisions-637328210449116117-637453773531398197.docx](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [University of Southern California](#)

Co.2 Point of Contact: [Soeren, Mattke, mattke@usc.edu](#), 202-468-2059-

Co.3 Measure Developer if different from Measure Steward: [University of Southern California](#)

Co.4 Point of Contact: [Soeren, Mattke, mattke@usc.edu](#), 202-468-2059-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[An interdisciplinary group of behavioral health experts was used to rate the face validity and usability of the measure. Their names and affiliations are provided in the Testing Form.](#)

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2017](#)

Ad.3 Month and Year of most recent revision: [01, 2021](#)

Ad.4 What is your frequency for review/update of this measure? [annual](#)

Ad.5 When is the next scheduled review/update for this measure? [12, 2021](#)

Ad.6 Copyright statement: [Some proprietary codes are contained in the measure specifications for convenience of the user. Use of these codes may require permission from the code owner or agreement to a license.](#)

[ICD-10 codes are copyrighted © World Health Organization \(WHO\), Fourth Edition, 2021. CPT © 2021 American Medical Association. CPT is a registered trademark of the American Medical Association. All rights reserved.](#)

Ad.7 Disclaimers: [This performance measure does not establish a standard of medical care and has not been tested for all potential applications.](#)

Ad.8 Additional Information/Comments: [We combined the 2019 submission of testing data and this 2021 submission with empirical validity testing, information on use and updated specifications to meet the reevaluation requirements](#)