NATIONAL QUALITY FORUM
Driving measurable health improvements together

Behavioral Health and Substance Use, Spring 2021 Cycle: CDP Report

TECHNICAL REPORT
FEBRUARY 7, 2022

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

https://www.qualityforum.org

Contents

Executive Summary

Behavioral health looks at how human behaviors and choices impact mental and physical health. Behavioral health comprises broader concepts, including mental wellness and substance use disorders (SUDs). These two main aspects of behavioral health often occur together and may affect each other [1] Quality measurement and quality improvement tools remain an important aspect of assessing and improving the treatment of behavioral health conditions.

At present, there are 45 NQF-endorsed behavioral health measures. NQF's most recent Behavioral Health and Substance Use (BHSU) Standing Committee roster and measure evaluation meeting materials are available on NQF's project webpage. This Standing Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of behavioral health and substance use services.

During the spring 2021 measure evaluation cycle, the BHSU Standing Committee evaluated one maintenance measure against NQF's standard evaluation criteria: #3175 *Continuation of Pharmacotherapy for Opioid Use Disorder (University of Southern California)*. This measure centers around the treatment of SUDs. The Standing Committee recommended the measure for endorsement, and the Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendation.

A summary of the measure is included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for the measure are in Appendix A.

Introduction

Behavioral health is a broad term that includes a range of services intended to treat mental disorders and SUDs, support those who suffer from or are recovering from these conditions, and promote behaviors that result in the well-being of the body and mind. Behavioral health services may focus on illnesses or conditions such as anxiety disorders, attention-deficit/hyperactivity disorder, disruptive behavioral disorders, depression and other mood disorders, eating disorders, personality disorders, posttraumatic stress disorder, schizophrenia spectrum and other psychotic disorders, and SUDs. In some cases, mental illness and SUD may occur together and either contribute to or worsen the other. In other instances, the disorders simply occur independently.[1]

The 2019 Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), a comprehensive annual report of behavioral health prevalence data, found that in the United States (U.S.), 20.6 percent of persons 18 years of age or older had a mental illness, 7.7 percent of persons 18 years of age or older suffered from an SUD, and 3.8 percent of persons 18 years of age or older had both an SUD and a mental illness. According to the data, 61.2 million Americans, or roughly 24.5 percent of the adult population, had a mental illness and/or SUD in 2019, which is a 5.9 percent increase from 2018. This information aligns with other epidemiologic studies that demonstrate the increasing prevalence of behavioral health conditions in the U.S [2] For example, opioid use disorder (OUD) is becoming a bigger concern in the U.S., with opioid overdose deaths at nearly 47,000 in 2018 alone.[3] While medications for OUD and other SUDs have been shown to reduce mortality and morbidity associated with OUD and SUD, only 10.3 percent of persons ages 12 years and older with SUDs reported receiving treatment during that year, and only 44.8 percent of persons ages 18 years and older with any mental illness reported receiving care for that condition.[2] This gap between behavioral health pathology and treatment alone represents an unmet need among those with behavioral health conditions.

The treatment of behavioral health illnesses often poses complex challenges. Mental illnesses and SUD are typically cycling, chronic, and serious. Additionally, the stigma surrounding these conditions further complicates treatment.[4–6] However, many evidence-based approaches exist to prevent such illnesses and to treat persons and families affected by them. Quality measurement[7–10] and quality improvement tools are essential to assessing and improving the quality of behavioral healthcare and patients' outcomes.

NQF Portfolio of Performance Measures for Behavioral Health and Substance Use Conditions

The BHSU Standing Committee (Appendix C) oversees NQF's portfolio of Behavioral Health and Substance Use measures (Appendix B), which includes measures for alcohol and drug use, care coordination, depression, medication use, experience of care, tobacco, and physical health. This portfolio contains 38 measures: 32 process measures and six outcome measures.

Additional measures have been assigned to other portfolios. These include healthcare-associated infection measures (Patient Safety), care coordination measures (Geriatrics and Palliative Care), imaging efficiency measures (Cost and Resource Use), and a variety of condition- or procedure-specific outcome measures (Cardiovascular, Cancer, Renal, etc.).

Behavioral Health and Substance Use Measure Evaluation

On June 17, 2021, the BHSU Standing Committee evaluated one measure undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 1. Behavioral Health and Substance Use Measure Evaluation Summary

Measure Summary	Maintenance	New	Total
Measures Under Review	1	0	1
Measures Endorsed	1	0	1

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on April 22, 2021, and pre-evaluation commenting closed on June 3, 2021. One comment was submitted and shared with the Standing Committee prior to the measure evaluation meeting (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on September 9, 2021. Following the Standing Committee's evaluation of the measure under review, NQF received no comments pertaining to the draft report and to the measure under review (Appendix G). All comments for the measure under review are summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for the measure submitted for endorsement consideration to inform the Standing Committee's recommendations during the commenting period. This expression of support (or not) during the commenting period replaces the member voting opportunity that was previously held subsequent to the Standing Committee's deliberations. No NQF members expressed "support" or "do not support" for the measure.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for the measure are included in Appendix A.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder (University of Southern California): Endorsed

Description: 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; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Health Plan, Clinician: Individual, Population: Regional and State; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This state-, health plan-, and clinician-level measure was originally endorsed in 2017 at the state and health plan levels and in 2019 at the clinician, group, and individual levels. The Standing Committee briefly discussed the new guidelines that the developer provided since the 2017 review and agreed that the guidelines strengthened the measure's evidence. The Standing Committee decided to accept the previous Standing Committee's review. The Standing Committee also noted that the two-year rolling period of performance scores for the measure at the state and health plan levels from 2010-2015 and for the individual clinician and clinician group/practice levels from 2013-2016 demonstrated a gap in performance. The Standing Committee expressed concern about disparities and inquired whether the measure was specified to decrease disparities in care. The developer noted that the ultimate goal was to encourage improvement, and therefore, they did not want to stratify the data out of concern that the data might reduce motivation for improvement from organizations or individuals who serve more minorities. A Standing Committee member requested the rationale for setting the time frame of at least 180 days of continuous treatment. In response, the developer replied that although there was a lack of data regarding the ideal time, anywhere from 180 days to three years appeared to be an acceptable time frame based on the available data. This measure was not reviewed by the Scientific Methods Panel (SMP).

During the reliability discussion, the Standing Committee noted that while the reliability results were better at the health plan and state levels of analysis, all reliability scores were greater than 0.7, which indicated sufficient signal strength to discriminate performance. While reviewing the face validity results that the developer provided, a Standing Committee member expressed concern that only two-thirds of the respondents for the clinician level of analysis found this measure to be valid. The developer explained that with such small numbers, that result is still considered acceptable. The other Standing Committee members agreed and highlighted that empirical validity was also conducted at the clinician levels of analysis, and the results indicated the measure was valid at the individual clinician and group levels of analysis. While empirical validity testing was not conducted at the state and health plan levels of analysis (as is required at maintenance review), the Standing Committee agreed that the face validity was strong, and the developer's rationale was acceptable, which stated that if the measure is valid at the clinician level, it will also be valid at the state and health plan levels. The Standing Committee passed the measure on the scientific acceptability criteria.

The Standing Committee did not have any concerns about feasibility, use, or usability but questioned whether any guidance was available to providers who were trying to improve care. The developer noted that they were interested in providing more guidance but are currently unable to implement it within the confines of this measure. The Standing Committee ultimately passed the measure on overall suitability. The developer submitted a comment that was received during the pre-evaluation commenting period. This comment clarified certain aspects of the measure.

NQF did not receive any post-evaluation comments on the Standing Committee's recommendation or the Draft Technical Report. Since no comments were received and the measure did not require further discussion or voting from the Standing Committee, the post-comment web meeting scheduled for October 8, 2021, was cancelled. During the CSAC meeting on November 30, 2021, the CSAC also did not express any concerns about the measure. The CSAC unanimously voted to uphold the Standing Committee's recommendation and endorsed the measure.

References

1 Centers Disease Control and Prevention (CDC). More than a mental health problem. Centers for Disease Control and Prevention. https://www.cdc.gov/vitalsigns/suicide/index.html. Published November 27, 2018. Last accessed July 2021.

2 Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2020. https://www.samhsa.gov/data/.

3 Kamal R. What are the current costs and outcomes related to mental health and substance use disorders? Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/. Published July 31, 2017. Last accessed July 2021.

4 Mental Health Myths and Facts | MentalHealth.gov. MentalHealth.gov. https://www.mentalhealth.gov/basics/mental-health-myths-facts. Published August 9, 2017. Last accessed July 2021.

5 Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, DC: National Academies Press (US); 2006. https://www.ncbi.nlm.nih.gov/books/NBK19830/. Last accessed July 2021.

6 Schaefer JA, Ingudomnukul E, Harris AHS, et al. Continuity of care practices and substance use disorder patients' engagement in continuing care. *Med Care*. 2005;43(12):1234-1241.

7 Duckworth M.D. K, Hosking Ph.D. R, Brister Ph.D. T, et al. Advancing Discovery for New, Better Treatments | NAMI: National Alliance on Mental Illness. https://www.nami.org/About-NAMI/NAMI-News/2019/Advancing-Discovery-for-New-Better-Treatments. Published February 2019. Last accessed July 2021.

8 Tanenbaum SJ. Evidence-based practice as mental health policy: three controversies and a caveat. *Health Affairs*. 2005;24(1):163-173.

9 Weil AR. Behavioral Health. *Health Affairs*. 2016;35(6):955-955.

10 Whitaker R. *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. Paperback edition. New York: Broadway Books; 2015. https://www.penguinrandomhouse.com/books/189611/anatomy-of-an-epidemic-by-robert-whitaker/9780307452429. Last accessed July 2021.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present during the meeting for that vote as the denominator. Denominator vote counts may vary throughout the criteria due to intermittent Standing Committee attendance fluctuation. The vote totals reflect members present and eligible to vote at the time of the vote. If quorum is not achieved or maintained during the meeting, the Standing Committee receives a recording of the meeting and a link to submit online votes. Quorum (a minimum of 16 out of 23 active Standing Committee members present) was reached and maintained for the full duration of the measure evaluation meeting on June 17, 2021.

Measures Endorsed

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Measure Worksheet | Specifications

Description: 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

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

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

Exclusions: There are no denominator exclusions.

Adjustment/Stratification: No risk adjustment or risk stratification. Measure results may be stratified by the following factors:

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

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

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: University of Southern California

STANDING COMMITTEE MEETING 06/17/2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Accepted Previous Decision**; 1b. Performance Gap: **Total votes: 17; H-6**; **M-11**; **L-0**; **I-0**

Rationale

- After reviewing two new additional guidelines on pharmacotherapy for OUD that supported the duration of methadone treatment and effectiveness of medication, the Standing Committee agreed that the updated evidence was directionally the same and even stronger compared with the evidence from NQF's previous review. The Standing Committee determined that additional discussion and a vote were not needed for the evidence criterion.
- The Standing Committee noted that the two-year rolling period of performance scores for the measure at the state (mean ranging from 25 to 30.7%) and health plan (mean ranging from 22.5 to 27.7%) levels from 2010–2015 and for the individual clinician (mean ranging from 37.77 to

40.96%) and clinician group/practice levels (mean ranging from 50.11 to 51.90%) from 2013–2016 demonstrated a gap in performance.

- The Standing Committee noted that the measure score was highest in individuals less than 65 years of age and decreased as the age ranges increased. Additionally, scores were higher for males than females, for White patients than for all others, and for dual-eligible beneficiaries than for non-dual-eligible ones.
- The Standing Committee inquired whether the measure was specified to decrease disparities in care. The developer noted that the goal was to encourage improvement, and therefore, they did not want to stratify the data out of concern that the data might reduce motivation for improvement from organizations or individuals who serve more minorities.
- The Standing Committee accepted this rationale and passed the measure on performance gap.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total votes; 17; H-2**; **M-15**; **L-0**; **I-0**; 2b. Validity: **Total votes: 17; H-0; M-14**; **L-3**; **I-0**

Rationale

- The SMP did not review this measure because it is considered a non-complex measure.
- A Standing Committee member requested the rationale for setting the time frame of at least 180 days of continuous treatment. The developer replied that although there was a lack of data regarding the ideal time, anywhere from 180 days to three years appeared to be an acceptable time frame based on the available data.
- The Standing Committee noted that the developer performed score-level testing using Adams' approach and computed the reliability using the beta-binomial model at the state, health plan, individual clinician, and clinician group/practice levels. Reliability testing was done using 2013–2014 data for the state and health plan levels and 2013–2016 data for the individual clinician and clinician group/practice levels.
- The Standing Committee noted that while reliability results were better at the health plan and state levels of analysis, all reliability scores were greater than 0.7, which indicated sufficient signal strength to discriminate performance.
- The Standing Committee noted that face validity was performed at the health plan and state levels with 10 experts and at the individual clinician and clinician group/practice levels with nine experts. Empirical validity testing was also conducted at the clinician levels of analysis.
- A Standing Committee member expressed concern that only two-thirds of the respondents for the clinician level of analysis found this measure to be valid. The developer explained that with such small numbers, that result is still considered acceptable. The other Standing Committee members agreed and highlighted that empirical validity testing was also conducted at the clinician levels of analysis, and the results indicated the measure was valid at the individual clinician and clinician group levels of analysis.
- While empirical validity testing was not conducted at the state and health plan levels of analysis (as is required at maintenance review), the Standing Committee agreed that the face validity was strong, and the developer's rationale was acceptable, which stated that if the measure is valid at the clinician level, it will also be valid at the state and health plan levels.
- The Standing Committee passed the measure on the scientific acceptability criteria.

3. Feasibility: Total votes: 17; H-11; M-6; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale

- The Standing Committee had no significant concerns with the feasibility of the measure and noted that while the data are coded by someone other than the person obtaining the original information, they are available in defined fields from electronic sources.

4. Use and Usability

(4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total votes: 17; Pass-17; No Pass-0**; 4b. Usability: **Total votes: 16; H-7; M-9; L-0; I-0**

Rationale

- The Standing Committee noted that the measure has been in use since 2019 as part of the following programs: the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program at the individual clinician and clinician group/practice levels, the Medicaid 1115 Substance Use Disorder Demonstrations at the state level in 21 states, and North Carolina´s Transformation to Medicaid Managed Care at the health plan level.
- The Standing Committee also highlighted that users of the measure were able to provide feedback and that no unintended consequences have been identified yet.
- The Standing Committee stated that both the commercial and Medicare data show improvement in scores over time as well as a steady increase in the size of the denominator, suggesting that pharmacotherapy for OUD is becoming more common, and continuity of care has improved. Results at the individual clinician and group/practice levels are too recent to show improvement over time.
- The Standing Committee questioned why guidance was unavailable to providers attempting to improve care and advocated to the developer to consider this in the future. The developer noted that they were interested in providing more guidance but are currently unable to implement it within the confines of this measure.

5. Related and Competing Measures

- This measure is related to the following measure(s):
    - #0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- The Standing Committee agreed that the measures were related and encouraged the developers to continue to harmonize the measures as much as possible.

6. Standing Committee Recommendation for Endorsement: **Total votes: 16; Y-15**; **N-1**

7. Public and Member Comment

- The developer submitted a public comment that was received prior to the measure evaluation meeting on June 17, 2021. This comment clarified certain aspects of the measure.
- No public comments were received on the Draft Technical Report or the measure following the measure evaluation meeting on June 17, 2021.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-10; N-0 (November 30, 2021): Endorsed

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received for this measure.

Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs*

NQF #	Title	Federal Programs (Finalized or Implemented)
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	None
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Merit-Based Incentive Payment System (MIPS) Medicare Shared Savings Program (MSSP) Physician Compare
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	Merit-Based Incentive Payment System (MIPS) Million Hearts Medicaid Promoting Interoperability Program for Eligible Professionals Physician Compare
0073	Ischemic Vascular Disease (IVD): Blood Pressure Control	None
0104e	Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-Based Incentive Payment System (MIPS) Medicaid Promoting Interoperability Program Physician Compare
0105	Antidepressant Medication Management (AMM)	Marketplace QRS Medicaid HEDIS Quality Measure Rating System
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Medicaid HEDIS Quality Measure Rating System
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Medicaid
0640	HBIPS-Two Hours of Physical Restraint Use	Hospital Compare Inpatient Psychiatric Facility Quality Reporting
0641	HBIPS-Three Hours of Seclusion Use	Hospital Compare Inpatient Psychiatric Facility Quality Reporting
0710e	Depression Remission at 12 Months (eMeasure)	Merit-Based Incentive Payment System (MIPS) Medicaid Promoting Interoperability Program for Eligible Professionals Physician Compare
0711	Depression Remission at Six Months	Merit-Based Incentive Payment System (MIPS) Program Medicare Shared Savings Program
0712	Depression Utilization of the PHQ-9 Tool	HEDIS Quality Measure Rating System

NQF #	Title	Federal Programs (Finalized or Implemented)
1879	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Merit-Based Incentive Payment System (MIPS) Medicaid HEDIS Quality Measure Rating System
1884	Depression Response at Six Months-Progress Towards Remission	None
1885	Depression Response at 12 Months-Progress Towards Remission	Merit-Based Incentive Payment System (MIPS) Physician Compare
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	None
1933	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	None
1934	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	HEDIS Quality Measure Rating System
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Merit-Based Incentive Payment System (MIPS) Physician Compare
2605	Follow-Up After Discharge From the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	None
2607	Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	None
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	None
2806	Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	None

NQF #	Title	Federal Programs (Finalized or Implemented)
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	None
3312	Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs	Medicaid
3313	Follow-Up Care for Adult Medicaid Beneficiaries Who Are Newly Prescribed an Antipsychotic Medication	Medicaid
3332	Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	None
3389	Concurrent Use of Opioids and Benzodiazepines (COB)	Medicaid
3400	Use of Pharmacotherapy for Opioid Use Disorder (OUD)	HEDIS Quality Measure Rating System Medicaid
3453	Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)	Medicaid
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	None
3489	Follow-Up After Emergency Department Visit for Mental Illness	None
3539e	Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting	None
3541	Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)	Marketplace Quality Rating System (QRS)
3589	Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)	None
3590	Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment	None

* CMS Measures Inventory Tool Last Accessed on January 31, 2022.

Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

STANDING COMMITTEE

Harold Pincus, MD (Co-Chair)
Professor and Vice Chair of Psychiatry and Co-Director of the Irving Institute for Clinical and Translational Research, Columbia University
New York, New York

Michael Trangle, MD (Co-Chair)
Senior Fellow, HealthPartners Institute for Research and Education
Bloomington, Minnesota

Loretta (Ann) Bostic, DNP, MBA, APRN, CRNA, PMHNP-BC
Program Director, MedSurg Behavioral Health Services
Charleston, West Virginia

Caroline Carney, MD, MSc, FAMP, CPHQ
Chief Medical Officer, Magellan Rx Management, Magellan Health, Inc.
Phoenix, Arizona

Vitka Eisen, MSW, EdD
President and Chief Executive Officer, HealthRIGHT 360
San Francisco, California

Julie Goldstein Grumet, PhD
Director of Zero Suicide Institute/Senior Health Care Advisor, Suicide Prevention Resource Center
Education Development Center
Washington, District of Columbia

Benjamin Han, MD, MPH
Assistant Professor, University of California, San Diego
La Jolla, California

Morissa Henn, MPH, DrPH
Community Health Director, Intermountain Healthcare
Salt Lake City, Utah

Lisa Jensen, DNP, APRN
Director of Clinical Operations, Specialty Care Services, Veterans Health Administration
North Salt Lake, Utah

Caitlyn Kjolhede, BSN, MBA (Inactive)
Vice President of Clinical Performance, CHESS Health
East Rochester, New York

Kraig Knudsen, PhD
Chief, Bureau of Research and Evaluation, Ohio Department of Mental Health and Addiction Services
Columbus, Ohio

Barbara Lang, LPC, LISAC
Deputy Chief of Standards and Compliance, Community Bridges, Inc.
Yuma, Arizona

Michael R. Lardieri, LCSW
Assistant Vice President Strategic Program Development, Northwell Health, Behavioral Health Services Line
Glen Oaks, New York

Raquel Mazon Jeffers, MPH, MIA
Senior Director, US Initiatives, Community Health Acceleration Partnership
Hopewell, New Jersey

Brooke Parish, MD
Executive Medical Director, Health Care Service Corporation, Blue Cross Blue Shield of New Mexico
Albuquerque, New Mexico

David Pating, MD
Associate Clinical Professor, Addiction Psychiatry – Substance Use Services, San Francisco Department of Public Health
San Francisco, California

Vanita Pindolia, PharmD
Vice President, Ambulatory Clinical Pharmacy Programs, Henry Ford Health System (HFHS)/Health Alliance Plan (HAP)
Detroit, Michigan

Chantelle Rice Collins, OTD, OTR/L, CDCES
Associate Professor, University of Southern California
Los Angeles, California

Andrew Sperling, JD
Director of Federal Advocacy, National Alliance on Mental Illness
Arlington, Virginia

Jeffery Susman, MD
Dean and VPHA, Emeritus, Northeast Ohio Medical University
Rootstown, Ohio

Allen Tien, MD
President and Director of Applied Research, Medical Decision Logic, Inc.
Baltimore, Maryland

Patrick Triplett, MD
Clinical Director and Physician Advisor, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine
Baltimore, Maryland

Heidi Waters, MBA, PhD
Director, Health Economics and Outcomes Research, Otsuka Pharmaceutical Development and Commercialization, Inc.

Rockville, Maryland

Bonnie Zima, MD, MPH
Professor in Residence, Child and Adolescent Psychiatry, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles (UCLA)
Los Angeles, California

NQF STAFF

Kathleen Giblin, RN
Acting Senior Vice President, Measurement Science and Application

Sheri Winsper, RN, MSN, MSHA
Senior Vice President, Measurement Science and Application *(former)*

Tricia Elliott, DHA, MBA, CPHQ, FNAHQ
Senior Managing Director, Measurement Science and Application

Michael Katherine Haynie
Senior Managing Director, Measurement Science and Application *(former)*

Matt Pickering, PharmD
Senior Director, Measurement Science and Application

Poonam Bal, MHSA
Senior Director, Measurement Science and Application

Tamara H. Funk, MPH
Director, Measurement Science and Application

Erin Buchanan, MPH
Manager, Measurement Science and Application

Yemsrach Kidane, PMP
Project Manager, Program Operations

Monika Harvey, MBA, PMP
Project Manager, Program Operations

Hannah Ingber, MPH
Senior Analyst, Measurement Science and Application

Sean Sullivan, MA
Associate, Measurement Science and Application

Gus Zimmerman, MPP
Associate, Measurement Science and Application

Jesse Pines, MD, MS, MBA
Consultant

Appendix D: Measure Specifications

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Steward

University of Southern California

Description

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

Type

Process

Data Source

Claims 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.

Level

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

Setting

Outpatient Services

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

Numerator Details

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 revaluating 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

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.

Cousins G, Teljeur C, Motterlini N, McCowan C, Dimitrov BD, Fahey T. Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study. J Subst Abuse Treat 2011; 41: 252–60.

Cousins G, Boland F, Courtney B, Barry J, Lyons S, Fahey T. Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. Addiction. 2016;111(1):73-82.

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.

“Drug Misuse and Dependence—Guidelines on Clinical Management.” Scottish Office Department of Health, Welsh Office, Social Services Northern Ireland. London: Stationery Office, 1999.

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.

Gruber VA, Delucchi KL, Kielstein A, Batki SL. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug and Alcohol Dependence. 2008;94(1-3):199-206.

Hser YI, Evans E, Grella C, Ling W, Anglin D. Long-term course of opioid addiction. Harvard Review of Psychiatry. 2015;23(2):76-89.

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.

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.

U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Review of Medication-Assisted Treatment Guidelines and Measures for Opioid and Alcohol Use. Washington, DC, 2015. Accessed November 9, 2016 at: https://aspe.hhs.gov/sites/default/files/pdf/205171/MATguidelines.pdf

U.S. Food and Drug Administration (FDA) (a). REVIA Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf

U.S. Food and Drug Administration (FDA) (b). VIVITROL Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021897lbl.pdf

Weiss RD; Potter JS; Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug and Alcohol Dependence. 2015;150:112-119.

Denominator Statement

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

Denominator Details

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.

Exclusions

There are no denominator exclusions.

Exclusion details

There are no denominator exclusions.

Risk Adjustment

No risk adjustment or risk stratification

Stratification

Measure results may be stratified by:

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

Type Score

Rate/proportion better quality = higher score

Algorithm

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 123001| 148777| 141015| 150289

Copyright / Disclaimer

Appendix E: Related and Competing Measures

Comparison of NQF #3175 and NQF #0004

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder
#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Steward

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

University of Southern California

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

National Committee for Quality Assurance

Description

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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

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

This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported:

- Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

Type

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Process

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

Process

Data Source

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Claims 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.

No data collection instrument provided Attachment NQF_3175_OUD_Code_Lists_2021_version.xlsx

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

Claims NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS).

No data collection instrument provided Attachment 0004_IET_Value_Sets.xlsx

Level

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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

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

Health Plan

Setting

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Outpatient Services

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

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

Numerator Statement

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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

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

Initiation of AOD Treatment:

Initiation of treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.

Engagement of AOD Treatment:

Initiation of AOD treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit.

Numerator Details

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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 revaluating 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

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.

Cousins G, Teljeur C, Motterlini N, McCowan C, Dimitrov BD, Fahey T. Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study. J Subst Abuse Treat 2011; 41: 252–60.

Cousins G, Boland F, Courtney B, Barry J, Lyons S, Fahey T. Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. Addiction. 2016;111(1):73-82.

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.

"Drug Misuse and Dependence—Guidelines on Clinical Management." Scottish Office Department of Health, Welsh Office, Social Services Northern Ireland. London: Stationery Office, 1999.

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.

Gruber VA, Delucchi KL, Kielstein A, Batki SL. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug and Alcohol Dependence. 2008;94(1-3):199-206.

Hser YI, Evans E, Grella C, Ling W, Anglin D. Long-term course of opioid addiction. Harvard Review of Psychiatry. 2015;23(2):76-89.

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.

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.

U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Review of Medication-Assisted Treatment Guidelines and Measures for Opioid and Alcohol Use. Washington, DC, 2015. Accessed November 9, 2016 at: https://aspe.hhs.gov/sites/default/files/pdf/205171/MATguidelines.pdf

U.S. Food and Drug Administration (FDA) (a). REVIA Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf

U.S. Food and Drug Administration (FDA) (b). VIVITROL Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021897lbl.pdf

Weiss RD; Potter JS; Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug and Alcohol Dependence. 2015;150:112-119.

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

Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.

- For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification, or ED visit (not resulting in an inpatient stay), the IESD is the date of service.
- For an inpatient stay, the IESD is the date of discharge.
- For an ED and observation visits that results in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).
- For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

INITIATION OF AOD TREATMENT

Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.

If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set).
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessment Value) set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List), initiation on the same day as the IESD must be with different providers in order to count.

- If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

• Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

ENGAGEMENT OF AOD TREATMENT

1) Numerator compliant for the Initiation of AOD Treatment numerator and

2) Members whose initiation of AOD treatment was a medication treatment event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event.

3) Remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2).

These members are numerator compliant if they meet either of the following:

• At least one engagement medication treatment event.

• At least two engagement visits

Two engagement visits can be on the same date of service, but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Engagement visits:

Any of the following meet criteria for an engagement visit:

• An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:

– Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

– Identify the admission date for the stay.

• IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

• Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

• IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

• IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Engagement Medication Treatment Events:

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total Column is not the sum of the diagnosis columns.

Denominator Statement

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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

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

Patients age 13 years of age and older as of December 31 of the measurement year who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).

Denominator Details

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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.

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

Identify the Index Episode. Identify all members 13 years and older as of December 31 of the measurement year who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:

– IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

– IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

– IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  - Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members, whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Select the Index Episode Start Date.

Exclusions

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

There are no denominator exclusions.

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

Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List) during the 60 days (2 months) before the IESD.

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusion Details

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

There are no denominator exclusions.

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

Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)

- For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

- For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

- For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

Risk Adjustment

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

Stratification

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Measure results may be stratified by:

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

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

The total population is stratified by age: 13-17 and 18+ years of age.

- Report two age stratifications and a total rate.
- The total is the sum of the age stratifications.

Report the following diagnosis cohorts for each age stratification and the total rate:

- Alcohol abuse or dependence.
- Opioid abuse or dependence.
- Other drug abuse or dependence.
- Total.

Type Score

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

Algorithm

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

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

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

Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified denominator criteria (S7-S9).

Step 2. Search administrative systems to identify numerator events for all patients in the eligible population (S6).

Step 3. Calculate the rate of numerator events in the eligible population.

Submission Items

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

5.1 Identified 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

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: 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.1 If competing, why superior or rationale for additive value: 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 0UD 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.

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

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

Appendix F: Pre-Evaluation Comments

Comments received as of June 3, 2021.

NQF #3175

Standing Committee Recommendation: Endorsed

Comment ID#: N/A

Commenter: University of South California (Measure Developer)

Council / Public: Public

Comment Period: Pre-Evaluation Public and Member Commenting

Date Comment was Submitted: 5/11/2021

Developer Response Required? No

Level of Support: N/A

Comment

After submission of the MIF, we detected an oversight. Our initial endorsement had used commercial claims data, and we had to restrict the age range to 18-64 years because of lack of data for the 65+ population. The most recent submission used Medicare data, and we requested expansion of the endorsed age range, but I forgot to make that change in the logic model. We will correct this error in the next submission.

We were unable to re-test the measure based on health plan data because we did not have access to those data, which are fairly expensive to obtain for an independent measure developer. Regarding empirical validity testing, we would argue, however, that demonstrating validity at the clinical and practice levels makes testing at a higher level of aggregation, like health plan or state, redundant. A health plan's score is simply the sum of scores for clinicians billing to it, and hence proving the relationship between measure scores and outcomes at a lower level of aggregation is sufficient.

Appendix G: Post-Evaluation Comments

No comments were received during the post-evaluation public commenting period.

National Quality Forum
1099 14th Street NW, Suite 500
Washington, DC 20005
https://www.qualityforum.org