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Full Measure Submission to Partnership for Quality Measurement

Scientific Acceptability

Validity

For each level of testing conducted, describe the method of validity testing and what it tests.*

Convergent Validity: To assess convergent validity, the team examined the correlations between CBE #3453 7-day and 14-day rates and HEDIS *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* (IET) measure (measurement year 2021, 18 and older age stratification, "initiation" indicator). The HEDIS IET measure assesses the percentage of individuals with new episode of alcohol or other drug abuse or dependence who initiated treatment within 14 days and received ongoing treatment within 34 days after initiation.

The measure developer also examined the correlation between CBE #3453 and CBE #3400, which represents the percentage of Medicaid beneficiaries aged 18 or older with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for OUD during the measurement year.

Face Validity: Results of the face-validity assessment, as captured in the TEP survey (for questions 4 through 14), showed a variety of opinions from the TEP respondents, with the majority of responses indicating some level of agreement with the face validity of CBE #3453.

Provide the statistical results from validity testing for each level of validity testing conducted.*

***Exhibit 8.* Convergent Validity: Correlation with HEDIS® IET Measures**

	CBE #3453 7-Day Rate		CBE #3453 14-Day Rate	
Measure	Spearman Correlation	p-value	Spearman Correlation	p-value
HEDIS® IET (Initiation, 18+) within 14 Days	0.66	<0.0001	0.68	<0.0001
HEDIS® IET (Initiation, 18+) within 30 Days	0.65	<0.0001	0.67	<0.0001
CBE #3400	0.70	<0.0001	0.72	<0.0001

Exhibit 9. **Measure Score Face Validity Results for Question 4:** ***This measure assesses continuity of care for adult Medicaid beneficiaries after inpatient or residential treatment for SUD.***

Response Option	Response (%)	Response (#)
Strongly Agree	75%	3
Agree	25%	1
Undecided	0%	0
Disagree	0%	0
Strongly Disagree	0%	0
No Not Know or Not Applicable	0%	0

Exhibit 10. **Measure Score Face Validity Results for Question 5:** ***Seven and 14 days after discharge are reasonable timeframes to assess for continuity of care after inpatient or residential treatment.***

Response Option	Response (%)	Response (#)
Strongly Agree	50%	2
Agree	50%	2
Undecided	0%	0
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	20%	1

Exhibit 11. **Measure Score Face Validity Results for Question 6:** ***Comparing scores for this measure meaningfully differentiates good performance from poor performance.***

Response Option	Response (%)	Response (#)
Strongly Agree	75%	3
Agree	25%	1
Undecided	0%	0
Disagree	0%	0
Strongly Disagree	0%	0
No Not Know or Not Applicable	0%	0

Exhibit 12. **Data Element Face Validity Results for Question 7:** ***Inpatient or residential settings can be identified by using all inpatient, outpatient, and ambulatory claims files or tables that contain HCPCS, ICD-10 diagnosis, place of service, or UB revenue codes. Residential treatment can be identified using codes in the SUD Residential Treatment value set.***

Response Option	Response (%)	Response (#)
Strongly Agree	50%	2
Agree	25%	1
Undecided	0%	0

Response Option	Response (%)	Response (#)
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	20%	1

Exhibit 13. **Data Element Face Validity Results for Question 8:** ***Discharges followed by admission or direct transfer to any inpatient setting (regardless of diagnosis), or to SUD residential treatment setting, within 7 or 14 days of the discharge (i.e., the continuity of care period) should be excluded, because these events may prevent a continuity of care visit from taking place.***

Response Option	Response (%)	Response (#)
Strongly Agree	50%	2
Agree	25%	1
Undecided	25%	1
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	0%	0

Exhibit 14. **Data Element Face Validity Results for Question 9:** ***Admission to residential treatment following discharge from inpatient treatment should be considered appropriate treatment in the assessment of continuity of care.***

Response Option	Response (%)	Response (#)
Strongly Agree	50%	2
Agree	50%	2
Undecided	0%	0
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	0%	0

Exhibit 15. **Data Element Face Validity Results for Question 10:** ***Continuity of care visits can be identified using outpatient claims files or tables that contain diagnosis, procedure, revenue codes, procedure code modifiers, or place of service codes.***

Response Option	Response (%)	Response (#)
Strongly Agree	25%	1
Agree	50%	2
Undecided	0%	0
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	25%	1

Exhibit 16. **Data Element Face Validity Results for Question 11:** ***Continuity of care visits with an SUD diagnosis in the primary or secondary position should be considered appropriate.***

Response Option	Response (%)	Response (#)
Strongly Agree	25%	1
Agree	50%	2
Undecided	0%	0
Disagree	25%	1
Strongly Disagree	0%	0
Do Not Know or Not Applicable	0%	0

Exhibit 17. **Data Element Face Validity Results for Question 12:** ***Telehealth is considered an appropriate continuity of care visit.***

Response Option	Response (%)	Response (#)
Strongly Agree	25%	1
Agree	50%	2
Undecided	25%	1
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	0%	0

Exhibit 18. **Data Element Face Validity Results for Question 13:** ***Pharmacotherapy is considered an appropriate continuity of care option.***

Response Option	Response (%)	Response (#)
Strongly Agree	25%	1
Agree	25%	1
Undecided	0%	0
Disagree	25%	1
Strongly Disagree	0%	0
Do Not Know or Not Applicable	25%	1

Exhibit 19. **Data Element Face Validity Results for Question 14:** ***Indications of pharmacotherapy can be identified in outpatient or pharmacy files or tables that contain the specified procedure codes or NDCs.***

Response Option	Response (%)	Response (#)
Strongly Agree	25%	1
Agree	25%	1
Undecided	0%	0
Disagree	0%	0
Strongly Disagree	0%	0
Do Not Know or Not Applicable	50%	2

Provide your interpretation of the results in terms of demonstrating validity.*

Convergent validity results. Performance score data for the HEDIS® IET measure show moderate correlation with both reported scores for CBE #3453, as presented in **Exhibit 8**. For the 7-day continuity of care score, the Spearman correlation coefficient was 0.66 with the IET 14-day treatment initiation score and 0.65 with the IET 34-day treatment initiation score. For the 14-day continuity of care score, the Spearman coefficient was 0.68 for the IET 14-day treatment initiation score and 0.67 with the 34-day treatment initiation score. Correlations with the CBE #3400 measure were strong (Spearman correlation coefficients of 0.70 with the CBE #3453 7-day continuity of care score and 0.72 with the CBE #3453 14-day continuity of care score. All correlations were statistically significant with $p<0.0001$.

CBE #3453 is rated strongly for validity. The majority of TEP respondents indicated that the measure has face validity and is able to distinguish between good quality and poor quality of care. In addition, convergent validity analysis shows strong (or high moderate) correlation with performance measures expected to perform similarly to CBE #3453.

Face validity results. The results shown above in **Exhibit 9**, all respondents either strongly agreed or agreed that CBE #3453 assesses continuity of care for adult Medicaid beneficiaries after inpatient or residential treatment for SUD (i.e., 75 percent strongly agreed, and the remaining 25 percent of respondents agreed). These findings suggest that the measure concept, as specified, is meaningful in assessing what it intends to assess.

Exhibit 10 shows that all respondents either strongly agreed or agreed that seven and 14 days after discharge are reasonable timeframes to assess for continuity of care after inpatient or residential treatment for SUD (i.e., 50 percent of respondents strongly agreed, and 50 percent agreed). These findings suggest that the timeframes used to assess timely follow-up in this measure are supported by stakeholder consensus.

In **Exhibit 11**, all respondents either strongly agreed or agreed that comparing scores for this measure meaningfully differentiates good performance from poor performance (i.e., 75 percent of respondents strongly agreed, and the remaining 25 percent of respondents agreed). These findings suggest that the measure, as specified, is useful in understanding and comparing the quality of care between different entities measured.

The results in **Exhibit 12** show that the majority of individuals responded *Strongly Agree* or *Agree*. One respondent (i.e., 25 percent) indicated *Do Not Know or Not Applicable*, as they were unsure if the codes adequately inform the measure. Overall, these findings suggest that the data elements defined in this measure for identifying the discharge episodes for the denominator are reasonable and useful in identifying the population of interest.

Exhibit 13 shows that the majority of individuals responded *Strongly Agree* or *Agree*. T One respondent (i.e., 25 percent) was undecided on the appropriateness of the exclusion, as they were unclear on the rationale behind it. Overall, hese findings suggest general stakeholder support for the exclusion of denominator episodes that are followed by an inpatient admission within the continuity of care assessment period.

In **Exhibit 14**, all respondents either strongly agreed or agreed that admission to residential treatment following discharge from inpatient treatment should be considered appropriate treatment in the assessment of continuity of care (i.e., 50 percent strongly agreed, and 50 percent agreed). These findings reflect stakeholder support for the continued inclusion of residential treatment as an option for care continuity in the numerator criteria.

The findings presented in **Exhibit 15** show that 75 percent of respondents either strongly agreed or agreed, that continuity of care visits can be identified using outpatient claims files or tables that contain diagnosis, procedure, revenue codes, procedure code modifiers, or place of service codes (i.e., 25 percent strongly agreed, and 50 percent agreed). One respondent (i.e., 25 percent) indicated *Do Not Know or Not Applicable*, as they were unsure of the various claims and coding systems that could be used to inform the measure. These results, as a whole, suggest that the data elements used to define the measure's numerator criteria are reasonable and useful for capturing services indicative of care continuity.

In **Exhibit 16**, 75 percent of respondents strongly agreed that continuity of care visits with an SUD diagnosis in the primary or secondary position should be considered appropriate for the measure's numerator (i.e., 25 percent strongly agreed, and an additional 50 percent of respondents agreed). One respondent (i.e., 25 percent) disagreed, stating that the SUD diagnosis should be in the primary position only. These results suggest that, while there may be slight disagreement on this topic, the majority of respondents supported the allowance of any diagnosis position for the SUD diagnosis on the continuity of care visit claim. Allowing any diagnosis position on the claim (i.e., primary or secondary), measured entities have a greater chance of satisfying the measure's numerator criteria.

In **Exhibit 17**, 75 percent of respondents either strongly agreed or agreed that telehealth should be considered an appropriate continuity of care visit (i.e., 25 percent strongly agreed, and an additional 50 percent of respondents agreed). One respondent (i.e., 25 percent) was undecided on this topic. These findings suggest that the majority of stakeholders are supportive of the allowance of telehealth modalities in the measure's numerator. Allowing telehealth services increases the ability of measured entities to satisfy the measure's criteria for a continuity of care visit.

Exhibit 18 shows that the majority of respondents stated *Strongly Agree* or *Agree* when asked if pharmacotherapy should be considered an appropriate continuity of care option. The findings from these results indicate that pharmacotherapy should be allowed as an appropriate continuity of care option in the numerator. A response of *Not Sure/Do Not Know* may be a byproduct of this stakeholder having a different understanding of the measure's intent, and thus, how the measure should define *continuity of care*.

The findings in **Exhibit 19** show that all respondents strongly agreed, agreed, or did not know if indications of pharmacotherapy can be identified in outpatient or pharmacy files, or tables that contain the specified procedure codes or NDCs (i.e., 25 percent strongly agreed, and 25 percent agreed). These findings suggest that the numerator criteria for pharmacotherapy, as specified, is reasonable and useful for identifying OUD pharmacotherapy events.