NATIONAL QUALITY FORUM

## Measure Information

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

### Brief Measure Information

**NQF #:** 0004
**Corresponding Measures:**
De.2. **Measure Title:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Co.1.1. **Measure Steward:** National Committee for Quality Assurance
De.3. **Brief Description of Measure:** 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.

1b.1. **Developer Rationale:** This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug dependence (AOD) services. By providing data on access to AOD dependence treatment across care settings, this measure provides insight on how plans and their providers may need to target education efforts and assists patient in accessing care.

S.4. **Numerator Statement:** 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.
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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.
S.6. **Denominator Statement:** 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).
S.8. **Denominator Exclusions:** 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.

De.1. **Measure Type:** Process
S.17. **Data Source:** Claims
S.20. **Level of Analysis:** Health Plan

**IF Endorsement Maintenance – Original Endorsement Date:** Aug 10, 2009 **Most Recent Endorsement Date:** Jun 10, 2019

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

De.4. **IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** N/A

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**
0004_IET_Evidence_Form.docx
**1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?**
Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.
Yes

**1b. Performance Gap**

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. **Briefly explain the rationale for this measure** *(e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)*
*If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*
This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug dependence (AOD) services. By providing data on access to AOD dependence treatment across care settings, this measure provides insight on how plans and their providers may need to target education efforts and assists patient in accessing care.

1b.2. **Provide performance scores on the measure as specified (current and over time) at the specified level of analysis**. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*
Initiation:
Medicaid
Measurement Year: 2016; 2017; 2018*
AVE: 38.24 40.87 42.28
N: 161 184 186
Min: 13.46 14.08 11.36
Max: 54.79 65.25 64.63
SD: 6.51 7.75 7.43
P10: 30.24 31.96 33.72
P25: 34.39 35.79 38.62
P50: 38.07 40.72 42.22
P75: 42.81 45.13 46.40
P90: 46.28 50.00 50.20
*Alcohol Diagnosis Stratification:
AVE: 40.96
N: 180
Min: 15.70

Max: 62.73
SD: 6.74
P10: 33.88
P25: 36.89
P50: 40.67
P75: 44.24
P90: 48.46
*Opioid Diagnosis Stratification:
AVE: 50.25
N: 173
Min: 19.64
Max: 74.71
SD: 11.52
P10: 34.94
P25: 40.99
P50: 50.84
P75: 58.62
P90: 65.22
*Other drug Diagnosis Stratification:
AVE: 42.46
N: 183
Min: 8.33
Max: 66.65
SD: 8.96
P10: 31.32
P25: 37.98
P50: 41.95
P75: 47.40
P90: 52.70

Medicare
Measurement Year: 2016; 2017; 2018*
AVE: 33.25 33.42 34.40
N: 397 404 408
Min: 5.26 3.93 5.98
Max: 86.10 87.88 89.35
SD: 12.21 13.23 13.11
P10: 18.29 15.59 15.21
P25: 25.44 25.26 27.01
P50: 33.33 33.63 35.06
P75: 41.03 40.92 41.71
P90: 45.95 48.78 48.30
* Alcohol Diagnosis Stratification:
AVE: 39.47
N: 370
Min: 8.82
Max: 89.82
SD: 11.33
P10: 24.52
P25: 32.86
P50: 40.40
P75: 45.52
P90: 51.47
*Opioid Diagnosis Stratification:

AVE: 31.61
N: 323
Min: 2.90
Max: 94.44
SD: 16.32
P10: 10.81
P25: 18.83
P50: 30.41
P75: 42.86
P90: 51.91
*Other Drug Diagnosis Stratification:
AVE: 32.55
N: 323
Min: 3.46
Max: 80.00
SD: 15.25
P10: 9.98
P25: 21.98
P50: 33.33
P75: 42.51
P90: 51.40

Commercial
Measurement Year: 2016; 2017; 2018*
AVE: 33.92 33.70 36.65
N: 405 401 384
Min: 13.16 15.69 12.12
Max: 54.61 78.69 83.20
SD: 5.28 6.33 7.67
P10: 27.86 27.54 29.39
P25: 30.61 30.59 33.02
P50: 34.02 33.18 35.85
P75: 36.59 35.91 39.18
P90: 40.44 40.60 42.01
*Alcohol Diagnosis Stratification:
AVE: 37.02
N: 377
Min: 19.57
Max: 80.48
SD: 7.42
P10: 29.75
P25: 33.44
P50: 36.56
P75: 39.77
P90: 43.37
*Opioid Diagnosis Stratification:
AVE: 41.76
N: 316
Min: 3.85
Max: 95.82
SD: 11.09
P10: 27.93
P25: 35.15
P50: 41.59

P75: 48.05
P90: 53.66
*Other Drug Diagnosis Stratification:
AVE: 37.79
N: 353
Min: 7.14
Max: 84.22
SD: 8.57
P10: 29.03
P25: 32.87
P50: 37.50
P75: 41.44
P90: 46.16

Engagement:
Medicaid
Measurement Year: 2016; 2017; 2018*
AVE: 10.31 12.66 13.55
N: 163 186 188
Min: 0.00 0.00 0.00
Max: 25.33 34.04 28.27
SD: 4.80 6.32 5.89
P10: 4.42 4.82 6.05
P25: 6.92 7.98 9.11
P50: 9.79 12.36 13.69
P75: 13.20 16.25 17.74
P90: 16.95 21.31 21.40
*Alcohol Diagnosis Stratification:
AVE: 10.71
N: 182
Min: 0.78
Max: 27.27
SD: 5.00
P10: 4.17
P25: 7.14
P50: 10.86
P75: 13.52
P90: 16.17
*Opioid Diagnosis Stratification:
AVE: 22.31
N: 175
Min: 1.46
Max: 48.87
SD: 11.63
P10: 7.34
P25: 13.10
P50: 21.23
P75: 31.48
P90: 37.48
*Other Drug Diagnosis Stratifcation:
AVE: 11.66
N: 185
Min: 0.00
Max: 28.75

SD: 5.64
P10: 4.38
P25: 8.09
P50: 11.29
P75: 15.15
P90: 18.95

Medicare
Measurement Year: 2016; 2017; 2018*
AVE: 3.14 3.52 4.21
N: 397 404 408
Min: 0.00 0.00 0.00
Max: 17.11 15.63 16.99
SD: 2.56 2.68 2.91
P10: 0.56 0.69 0.83
P25: 1.37 1.62 2.21
P50: 2.60 3.03 3.71
P75: 4.08 4.73 5.62
P90: 6.47 7.03 8.08
*Alcohol Diagnosis Stratification:
AVE: 4.57
N: 370
Min: 0.00
Max: 18.67
SD: 2.93
P10: 1.52
P25: 2.56
P50: 4.09
P75: 5.97
P90: 8.40
*Opioid Diagnosis Stratification:
AVE: 4.61
N: 323
Min: 0.00
Max: 26.60
SD: 4.33
P10: 0.50
P25: 1.55
P50: 3.38
P75: 6.28
P90: 10.23
*Other Drug Diagnosis Stratification:
AVE: 3.66
N: 323
Min: 0.00
Max: 17.50
SD: 3.43
P10: 0.00
P25: 1.00
P50: 2.80
P75: 5.62
P90: 8.33

Commercial

Measurement Year: 2016; 2017; 2018*
AVE: 12.65 12.09 13.40
N: 405 402 384
Min: 0.00 0.00 0.00
Max: 30.23 29.78 25.90
SD: 4.81 4.37 4.05
P10: 7.28 6.22 8.70
P25: 9.28 9.63 10.97
P50: 12.34 12.11 13.32
P75: 15.57 15.04 15.88
P90: 18.76 17.33 18.33
*Alcohol Diagnosis Stratification:
AVE: 12.84
N: 377
Min: 0.00
Max: 29.07
SD: 4.32
P10: 7.55
P25: 10.42
P50: 12.70
P75: 15.33
P90: 17.75
*Opioid Diagnosis Stratification:
AVE: 20.74
N: 316
Min: 1.41
Max: 44.18
SD: 8.11
P10: 10.62
P25: 14.62
P50: 20.30
P75: 26.58
P90: 30.95
*Other Drug Diagnosis Stratification:
AVE: 13.29
N: 353
Min: 0.00
Max: 25.49
SD: 4.79
P10: 7.04
P25: 10.10
P50: 13.12
P75: 16.50
P90: 19.70

1b.3. **If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**
Section 1b.2 references data from the most recent three years of measurement for this measure and includes average performance, N = number of health plans, min, max, standard deviation and percentiles (and where applicable stratification by diagnosis).

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

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

HEDIS data are stratified by type of insurance (e.g. commercial, Medicaid, Medicare). NCQA does not currently collect performance data stratified by race, ethnicity, or language. Escarce et al. have described in detail the difficulty of collecting valid data on race, ethnicity, and language at the health plan level (Escarce, 2011). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities. NCQA's Race/Ethnicity Diversity of Membership and the Language Diversity of Membership HEDIS® measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

Escare J.J., Carreon R., Vesolovskiy G., and Lawson E.H. 2011. Collection of Race and Ethnicity Data by Health Plans Has Grown Substantially, But Opportunities Remain to Expand Efforts. Health Affairs 20(10): 1984-1991.

The measure is not stratified to detect disparities. NCQA has participated with IOM and others in attempting to include information on disparities in measure data collection. However, at the present time, this data, at all levels (claims data, paper chart review, and electronic records), is not coded in a standard manner, and is incompletely captured. There are no consistent standards for what entity (physician, group, plan, employer) should capture and report this data. While "requiring" reporting of the data could push the field forward, it has been our position that doing so would create substantial burden with inability to use the data because of its inconsistency. At the present time, we agree with the IOM report that disparities are best considered by the use of zip code analysis which has limited applicability in most reporting situations. At the health plan level, for HEDIS health plan data collection, NCQA does have extensive data related to our use of stratification by insurance status (Medicare, Medicaid and private-commercial) and would strongly recommend this process where the data base supporting the measurement includes this information. However, we believe that the measure specifications should NOT require this since the measure is still useful where the data needed to determine disparities cannot be ascertained from the data available.

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

Although HEDIS measures are not stratified by race and ethnicity, others, including the Centers for Medicare and Medicaid Services (CMS) have explored disparities related to this quality measure. The CMS Office of Minority Health, in collaboration with the RAND Corporation, began releasing national level health care quality data for different racial/ethnic groups in 2016. The findings in the Racial and Ethnic Disparities in Health Care in Medicare Advantage report include clinical care measures and patient experience measures for Medicare beneficiaries, including the IET measure. Clinical care data are reported for Medicare Advantage beneficiaries via medical records and insurance claims for hospitalizations, medical office visits, and procedures. In 2014 the IET results indicated that Asians or Pacific Islanders and Hispanics initiated treatment within 14 days of a new episode and diagnosis of AOD abuse or dependence less frequently than Whites (CMS, 2016). Overall, 19.2 percent of Asians or Pacific Islanders; 18.2 percent of Hispanics; and 29.5 percent of Whites initiated appropriate treatment.

In 2014, Asian or Pacific Islander patients and Hispanic patients with a new episode of AOD abuse or dependence and who initiated treatment were less likely than White patients to have had two or more additional services within 30 days of the initiation visit. Overall, 1.4 percent of Asian and Pacific Islanders,1.4 percent of Hispanic and 2.6 percent of Whites had two or more additional services for their new diagnosis of AOD after initiation of treatment (CMS, 2016). Conversely, Blacks (32.5 percent) were more likely than Whites (29.5 percent) to initiate treatment within 14 days of an AOD diagnosis (CMS, 2016). However, Blacks (2.6 percent) were as likely as Whites (2.6 percent) to engage in treatment (i.e., two or more additional services with a diagnosis of AOD within 30 days of the initiation of treatment), according to 2014 findings (CMS, 2016).

Centers for Medicare and Medicaid Services Office of Minority Health. 2016. Racial and Ethnic Disparities in Health Care and Medicare Advantage. Baltimore, MD.

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

De.5. **Subject/Topic Area** *(check all the areas that apply):*
Behavioral Health, Behavioral Health : Alcohol, Substance Use/Abuse

De.6. **Non-Condition Specific***(check all the areas that apply):*
Care Coordination, Safety

De.7. **Target Population Category** *(Check all the populations for which the measure is specified and tested if any):*
Children, Elderly, Populations at Risk

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

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

S.2b. **Data Dictionary, Code Table, or Value Sets** *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*
Attachment **Attachment:** 0004_IET_Value_Sets.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.
No, this is not an instrument-based measure **Attachment:**

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.
Not an instrument-based measure

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

S.3.2. **For maintenance of endorsement,** please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.
Added dispensing of pharmacotherapy for treatment of alcohol and opioid abuse and dependence as appropriate initiation and engagement criteria. Medication-assisted treatment (MAT), or the use of medicine in addition to psychosocial care, is a guideline-supported treatment option for those with alcohol or opioid use disorders. Adding pharmacotherapy to the measure numerator aligns the included treatment options with current guidelines and literature.

- Added “telehealth” to the denominator and numerators. Telehealth is an evidence-supported modality for the treatment of patients with substance use disorders.

- Extended the Engagement of AOD Treatment time frame to 34 days from 30 days. The slight extension of the timeframe for engagement is to allow for all FDA-approved medication treatment (particularly the long-term injectable medications, such as naltrexone) options to be dispensed or administered, if used to satisfy the engagement criteria.

S.4. **Numerator Statement** *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.*
*IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*
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.
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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.

S.5. **Numerator Details** *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*
*IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*
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.

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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.

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

S.7. **Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*
*IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*
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.

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

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

S.10. **Stratification Information** *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that*

*exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*
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.

S.11. **Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)
No risk adjustment or risk stratification
If other:

S.12. **Type of score:**
Rate/proportion
If other:

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

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

S.15. **Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
N/A

S.16. **Survey/Patient-reported data** *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*
Specify calculation of response rates to be reported with performance measure results.
N/A

S.17. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
*If other, please describe in S.18.*
Claims

S.18. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*
IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.
NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS).

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

No data collection instrument provided

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

S.21. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Emergency Department and Services, Inpatient/Hospital, Outpatient Services
If other:

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

**2. Validity – See attached Measure Testing Submission Form**
NQF_MTF_IET.docx

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

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

**2.3 For maintenance of endorsement**
*Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.*
No - This measure is not risk-adjusted

## 3. Feasibility

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

**3a. Byproduct of Care Processes**

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

3a.1. **Data Elements Generated as Byproduct of Care Processes.**
Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)
If other:

**3b. Electronic Sources**

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

3b.1. **To what extent are the specified data elements available electronically in defined fields** (*i.e., data elements that are needed*

*to compute the performance measure score are in defined, computer-readable fields*) Update this field for **maintenance of endorsement**.
ALL data elements are in defined fields in a combination of electronic sources

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

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

**3c. Data Collection Strategy**

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

3c.1. **Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**
**IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.**
NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

1) Information practices and control procedures

2) Sampling methods and procedures

3) Data integrity

4) Compliance with HEDIS specifications

5) Analytic file production

6) Reporting and documentation

In addition to the HEDIS audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this
system, NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant

change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

3c.2. **Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** *(e.g., value/code set, risk model, programming code, algorithm)*.
Broad public use and dissemination of these measures, without modification, are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Modifications to, and/or commercial use of, a measure requires the prior written consent of NCQA and is subject to a license at the discretion of NCQA. As used herein, "commercial use" refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, even if there is no actual charge for inclusion of the measure .

## 4. Usability and Use

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

**4a. Accountability and Transparency**

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

4.1. **Current and Planned Use**

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

| Specific Plan for Use | Current Use (for current use provide URL) |
|---|---|
| | Public Reporting<br><br>Health Plan Rating<br>https://www.ncqa.org/hedis/reports-and-research/ratings-methodology-and-guidelines/<br>Annual State of Health Care Quality<br>http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality<br><br>Payment Program<br>Medicaid Adult Core Set<br>https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf<br>Merit Based Incentive Payment System (MIPS)<br>https://qpp.cms.gov/mips/quality-measures<br>Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives: Health Insurance Exchange Quality Rating System (QRS)<br>http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html<br><br>Regulatory and Accreditation Programs<br>NCQA Accreditation<br>http://www.ncqa.org/tabid/123/Default.aspx<br><br>Quality Improvement (external benchmarking to organizations)<br>Quality Compass<br>http://www.ncqa.org/hedis-quality-measurement/quality-measurement- |

| | |
|---|---|
| | products/quality-compass<br>Annual State of Health Care Quality<br>http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality |

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

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

MEDICAID ADULT CORE SET: There are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers of Medicare & Medicaid (CMS). The data collected from these measures helps CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and annually thereafter, the Secretary is required to publicly report the information that states voluntarily report to CMS on the quality of health care received by adults enrolled in Medicaid.

MERIT BASED INCENTIVE PAYMENT SYSTEM (MIPS) QUALITY PAYMENT PROGRAM (QPP): Eligible clinicians who elect to participate in MIPs earn a performance-based payment adjustment to Medicaid payments upon submission of evidence which attests that they provided high quality, efficient care supported by technology. Eligible clinicians can select up to six quality measures to report to CMS, including one outcome measure, that best fit their needs or specialty. The data collected from this program will help CMS to better understand the quality of health care that Medicare enrollees receive nationally.

HEALTH INSURANCE EXCHANGE QUALITY RATING SYSTEM (QRS): Qualified Health Plan (QHP) issuers and Multi-State Plan (MSP) issuers that offered coverage through a Health Insurance Marketplace (Marketplace) in the year prior to the current year are required to collect and submit QRS measure data to CMS. CMS produces quality ratings on a 5-star scale for each issuer in each State. Health plan level clinical quality measures and survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey) are included in the QRS measure set. CMS collects data and calculates quality ratings for each QHP issuer's product type within each state and applies these ratings to each product type's QHPs in that State.

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2017, the report included results from calendar year 2016 for health plans covering a record 182 million people, or 43 percent of the U.S. population

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used in the calculation of health plan ratings, which are reported on the NCQA website annually. These ratings are based on a plan's performance on their HEDIS, CAHPS and accreditation standards scores. In 2017, a total of 521 Medicare Advantage health plans, 614 commercial health plans and 294 Medicaid health plans across 50 states, D.C., Guam, Puerto Rico, and the Virgin Islands were included in the Ratings.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. As of Fall 2017, a total of 184 Medicare Advantage health plans were scored for accredition using this measure among others covering 9.2 million Medicare beneficiaries; 451 commercial health plans covering 113 million lives; and 125 Medicaid health plans covering 35 million lives. Health plans are scored based on performance compared to national benchmarks.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer comparison of plans' performance against competitors or benchmarks.

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

4a1.3. **If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6**

**years of initial endorsement.** (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)
N/A

4a2.1.1. **Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**
**How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.**
Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

4a2.1.2. **Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**
NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System.

4a2.2.1. **Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.**
**Describe how feedback was obtained.**
NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. **Summarize the feedback obtained from those being measured.**
In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions have generally centered around minor clarification of the specifications, such as calculating days of medication treatment and questions about the supporting guidelines for the measure. NCQA responded to all questions to ensure consistent implementation of the specifications.

4a2.2.3. **Summarize the feedback obtained from other users**
This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the CMS Quality Rating System (QRS), CMS Merit-Based Incentive Payment System (MIPS) Program, and the Medicaid Adult Core Set.

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

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

4b1. **Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)**
**If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

Over the past three years, this measure has shown slight improvement across health plans (see section 1b.2 for summary of data from health plans), although overall, still demonstrating that there is a significant gap in care and room for improvement across all product lines.

Overall, mean performance and distribution for the initiation of treatment (initiation indicator) was relatively similar among the Medicare, Medicaid and commercial products. Starting in 2018, data was stratified by diagnosis cohort (i.e., alcohol, opioid, or other drug abuse and dependence) to understand with more granularity how different subpopulations were initiating and engaging in treatment. For the initiation indicator, higher performance was seen among members with a diagnosis of opioid abuse and dependence than members with diagnoses of alcohol or other drug abuse and dependence.

Mean performance and distribution for the engagement in ongoing treatment (engagement indicator) among Medicaid and commercial products were very similar. However, performance was about 10 percentage points lower than what is observed in the Medicaid and commercial products. For the engagement indicator, higher performance was again seen among members with a diagnosis of opioid abuse and dependence than members with diagnoses of alcohol or other drug abuse and dependence.

**4b2. Unintended Consequences**

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

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

There were no identified unexpected benefits during implementation of this measure

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO´s ability to comply with HEDIS specifications (. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.
The HEDIS Compliance Audit addresses the following functions:
1) information practices and control procedures
2) sampling methods and procedures
3) data integrity
4) compliance with HEDIS specifications
5) analytic file production
6) reporting and documentation

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

N/A

## 5. Comparison to Related or Competing Measures

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

**5. Relation to Other NQF-endorsed Measures**

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

No

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

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

**5a. Harmonization of Related Measures**

The measure specifications are harmonized with related measures;
**OR**
The differences in specifications are justified

5a.1. **If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**
**Are the measure specifications harmonized to the extent possible?**

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

**5b. Competing Measures**

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

5b.1. **If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**
**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**
N/A

## Appendix

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

## Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance
Co.2 **Point of Contact:** Bob, Rehm, nqf@ncqa.org, 202-955-1728-
Co.3 **Measure Developer if different from Measure Steward:** National Committee for Quality Assurance
Co.4 **Point of Contact:** Kristen, Swift, swift@ncqa.org, 202-955-5174-

## Additional Information

Ad.1 **Workgroup/Expert Panel involved in measure development**
**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**
NCQA Behavioral Health Measurement Advisory Panel

Katharine Bradley, MD, MPH, Senior Investigator, Kaiser Permanente Washington Health Research Institute
Christopher Dennis, MD, MBA, FAPA, Chief Behavioral Health Officer, Landmark Health

Ben Druss, MD, MPH, Professor, Emory University

Frank Ghinassi, PhD, ABPP, President & CEO, Rutgers University Behavioral Health Care

Connie Horgan, ScD, Professor and Director, Institute for Behavioral Health, Brandeis University

Laura Jacobus-Kantor, PhD, Chief, Quality, Evaluation and Performance Branch, SAMHSA, HHS

Jeffrey Meyerhoff, MD, National Medical Director for Medicare and Retirement, Optum Behavioral Health

Harold Pincus, MD, Professor and Vice Chair--Department of Psychiatry, College of Physicians and Surgeons
Co-Director, Irving Institute for Clinical and Translational Research --Columbia University
Director of Quality and Outcomes Research--New York –Presbyterian Hospital
Senior Scientist--RAND Corporation

Michael Schoenbaum, PhD, Senior Advisor for Mental Health Services, Epidemiology and Economics, National Institute of Mental Health

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NCQA Committee on Performance Measurement (CPM)

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**Measure Developer/Steward Updates and Ongoing Maintenance**

Ad.2 **Year the measure was first released:** 2004

Ad.3 **Month and Year of most recent revision:** 01, 2012

Ad.4 **What is your frequency for review/update of this measure?** As needed, based on feedback from the field and changes to clinical guidelines and evidence.

Ad.5 **When is the next scheduled review/update for this measure?** 12, 2019



Ad.7 **Disclaimers:** This HEDIS® performance measure is not a clinical guideline and does not establish a standard of medical care and has not been tested for all potential applications.

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