



## 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 #: 3589**

**Corresponding Measures:**

**De.2. Measure Title:** Prescription or administration of pharmacotherapy to treat opioid use disorder (OUD)

**Co.1.1. Measure Steward:** RTI International

**De.3. Brief Description of Measure:** This measure reports the percentage of a provider's patients who were Medicaid beneficiaries ages 18 to 64 with an OUD diagnosis who filled a prescription for, or were administered or ordered, a FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider.

**1b.1. Developer Rationale:** In 2019, opioids were involved in 49,912 overdose deaths in the United States, a 6.6% annual increase from 2018. The two clinical milestones likely to have the greatest impact on lowering the risk of mortality from opioid use disorders are initiation of medications to treat opioid use disorder (MOUD) initiation and retention on MOUD (Ball & Ross, 1991; Degenhardt et al., 2011; Sordo et al., 2017; Volkow et al., 2019). Randomized clinical trials and observational studies find that individuals with an opioid use disorder (OUD) who are treated with an FDA-approved opioid use disorder medication (i.e., methadone, buprenorphine, naltrexone) have better outcomes than individuals who do not receive OUD medications such as larger reductions in mortality, opioid usage and relapses, rates of infectious disease, and emergency department and inpatient admissions, as well as improved functioning in major life domains (Clark et al., 2014; Clark et al., 2015; D'Onofrio et al., 2015; Fullerton et al., 2014; Haley et al., 2019; Jarvis et al., 2018; Larochelle et al., 2018; Lo-Ciganic et al., 2016; Ma et al., 2019; Mark et al., 2020; Mattick et al., 2003; Mattick et al., 2009; Mattick et al., 2014; Minozzi et al., 2011; Parran et al., 2010; Pierce et al., 2016; Schwarz et al., 2012; Sordo et al., 2017; Syed & Keating, 2013; Thomas et al., 2014; Williams et al., 2020; Woody et al., 2014). As described below, comprehensive reviews conclude that the evidence for the effectiveness of MOUD relative to non-medication based OUD treatment is of high to moderate quality (American Society of Addiction Medicine, 2015, 2020; Center for Substance Abuse Treatment, 2004, Center for Substance Abuse Treatment, 2005; Fullerton et al., 2014; Thomas et al., 2014, Mattick et al., 2014, Mattick et al., 2009, SAMHSA, 2020).

NQF endorsed Use of Pharmacotherapy (NQF #3400) – a measure of the percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for opioid use disorder (MOUD) during the measure year - at the health plan and Medicaid program level. The implementation of this measure is hypothesized to lead to more people receiving MOUD, improved health care outcomes, higher treatment costs, but lower overall costs because high-cost acute care utilization is reduced and the comorbidities associated with OUD are treated more effectively (See Figure 1. Logic model) (Busch et al., 2017; Clark et al., 2014; Clark et al., 2015; Florence et al., 2013; Mohlman et al., 2016; Mark et al., 2020; National Institute of Drug Abuse, 2019; Nielsen et al., 2016; Ronquest et al., 2018). The potential unintended consequences of the measure may include diversion and accidental overdoses, such as by children. A recent review of 17 studies finds that most people use illicit buprenorphine to self-medicate (to manage opioid withdrawal symptoms or achieve or maintain abstinence from other opioids), while a smaller percentage use it to get high (Chilcoat et al., 2019). Between 2004 and 2011, there were 5,222 emergency department visits by children ages 1 to 5 involving accidental ingestion of buprenorphine (Crane, 2017). To put that number in perspective, there were 8.2 million prescriptions for buprenorphine in 2012. Buprenorphine is available in an extended-release injectable form with no diversion potential and no potential for accidental ingestion.

Despite the clear benefits of MOUD, many practitioners do not offer them to their patients with OUD. In 2018, only 40% of specialty addiction treatment facilities offered medications to treat opioid use disorder (Mark et al., 2020). In 2015, between 31% and 37% of patients with OUD in specialty facilities received medications for OUD (SAMHSA, 2017). Many regions of the country lack an adequate supply of buprenorphine waived professionals (Abraham et al., 2020; Andrilla et al., 2020). A recent study in Massachusetts reported that only 30% of those who survived an opioid overdose received medications for OUD in the year after their overdose (Larochelle, 2018).

A 2014 American Society of Addiction Medicine expert panel recommended that the Use of Pharmacotherapy Measure (NQF #3400) be created as a measure at the clinician level (ASAM, 2014). They note that individual providers could use the measure for quality improvement and to monitor their practices (ASAM, 2014). The ASAM expert panel noted that the measure would be useful even though there is no set time when a patient with OUD should be initiated on MOUD or an absolute benchmark level to determine the appropriate percentages of patients on MOUD. They explain that ensuring timely treatment with OUD medications is important as data show that individuals who receive MOUD are more likely to be retained in addiction treatment (Mattick et al., 2014, Timko et al., 2016). Further, improved outcomes have been demonstrated for patients who initiate buprenorphine to treat OUD in emergency departments (D'Onofrio et al., 2015). Finally, as noted above, a large and robust portfolio of research highlights the significant mortality and morbidity benefits of MOUD.

A measure of use of MOUD for OUD is being reported and used at the provider level in four state Medicaid programs to help identify providers who could benefit from technical assistance (New York, Massachusetts, West Virginia, Delaware). The measure is also being used at the provider-level in Centers for Medicare and Medicaid (CMS) behavioral health home demonstrations; however, it has not been endorsed at the provider level (CMS, 2019).

**S.4. Numerator Statement:** Beneficiaries ages 18 to 64 with an OUD who filled a prescription for, or were administered or ordered, an FDA-approved medication for the treatment of OUD within 30 days of the first attributable encounter with an OUD diagnosis with the provider.

**S.6. Denominator Statement:** Number of Medicaid ages 18 – 64 beneficiaries with at least one medical claim for an encounter with an OUD diagnosis with that provider (where the provider is identified by a National Provider Identifier (NPI) code).

**S.8. Denominator Exclusions:** Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow up treatment medications (e.g. medication assisted treatment) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore, follow-up would be missed. Individuals under 18 are excluded. Rationale: There is limited evidence regarding the efficacy of MOUD for this population. Individuals over 64 are excluded: Rationale: Most individuals over age 64 are covered under Medicare. Services covered by Medicare would not be capture in the Medicaid claims data and therefore follow-up treatment would be missed.

**De.1. Measure Type:** Process

**S.17. Data Source:** Claims, Enrollment Data

**S.20. Level of Analysis:** Clinician : Individual, Facility

**IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:**

**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?**

## 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

[MOUD\\_Evidence\\_11\\_19\\_2020.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.

### 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.

In 2019, opioids were involved in 49,912 overdose deaths in the United States, a 6.6% annual increase from 2018. The two clinical milestones likely to have the greatest impact on lowering the risk of mortality from opioid use disorders are initiation of medications to treat opioid use disorder (MOUD) initiation and retention on MOUD (Ball & Ross, 1991; Degenhardt et al., 2011; Sordo et al., 2017; Volkow et al., 2019). Randomized clinical trials and observational studies find that individuals with an opioid use disorder (OUD) who are treated with an FDA-approved opioid use disorder medication (i.e., methadone, buprenorphine, naltrexone) have better outcomes than individuals who do not receive OUD medications such as larger reductions in mortality, opioid usage and relapses, rates of infectious disease, and emergency department and inpatient admissions, as well as improved functioning in major life domains (Clark et al., 2014; Clark et al., 2015; D'Onofrio et al., 2015; Fullerton et al., 2014; Haley et al., 2019; Jarvis et al., 2018; Larochelle et al., 2018; Lo-Ciganic et al., 2016; Ma et al., 2019; Mark et al., 2020; Mattick et al., 2003; Mattick et al., 2009; Mattick et al., 2014; Minozzi et al., 2011; Parran et al., 2010; Pierce et al., 2016; Schwarz et al., 2012; Sordo et al., 2017; Syed & Keating, 2013; Thomas et al., 2014; Williams et al., 2020; Woody et al., 2014). As described below, comprehensive reviews conclude that the evidence for the effectiveness of MOUD relative to non-medication based OUD treatment is of high to moderate quality (American Society of Addiction Medicine, 2015, 2020; Center for Substance Abuse Treatment, 2004, Center for Substance Abuse Treatment, 2005; Fullerton et al., 2014; Thomas et al., 2014, Mattick et al., 2014, Mattick et al., 2009, SAMHSA, 2020).

NQF endorsed Use of Pharmacotherapy (NQF #3400) – a measure of the percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for opioid use disorder (MOUD) during the measure year - at the health plan and Medicaid program level. The implementation of this measure is hypothesized to lead to more people receiving MOUD, improved health care outcomes, higher treatment costs, but lower overall costs because high-cost acute care utilization is reduced and the comorbidities associated with OUD are treated more effectively (See Figure 1. Logic model) (Busch et al., 2017; Clark et al., 2014; Clark et al., 2015; Florence et al., 2013; Mohlman et al., 2016; Mark et al., 2020; National Institute of Drug Abuse, 2019; Nielsen et al., 2016; Ronquest et al., 2018). The potential unintended consequences of the measure may include diversion and accidental overdoses, such as by children. A recent review of 17 studies finds that most people use illicit buprenorphine to self-medicate (to manage opioid withdrawal symptoms or achieve or maintain abstinence from other opioids), while a smaller percentage use it to get high (Chilcoat et al., 2019). Between 2004 and 2011, there were 5,222 emergency department visits by children ages 1 to 5 involving accidental ingestion of buprenorphine (Crane, 2017). To put that number in perspective, there were 8.2 million prescriptions for buprenorphine in 2012. Buprenorphine is available in an extended-release injectable form with no diversion potential and no potential for accidental ingestion.

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A 2014 American Society of Addiction Medicine expert panel recommended that the Use of Pharmacotherapy Measure (NQF #3400) be created as a measure at the clinician level (ASAM, 2014). They note that individual providers could use the measure for quality improvement and to monitor their practices (ASAM, 2014). The ASAM expert panel noted that the measure would be useful even though there is no set time when a patient with OUD should be initiated on MOUD or an absolute benchmark level to determine the appropriate percentages of patients on MOUD. They explain that ensuring timely treatment with OUD medications is important as data show that individuals who receive MOUD are more likely to be retained in addiction treatment (Mattick et al., 2014, Timko et al., 2016). Further, improved outcomes have been demonstrated for patients who initiate buprenorphine to treat OUD in emergency departments (D'Onofrio et al., 2015). Finally, as noted above, a large and robust portfolio of research highlights the significant mortality and morbidity benefits of MOUD.

A measure of use of MOUD for OUD is being reported and used at the provider level in four state Medicaid programs to help identify providers who could benefit from technical assistance (New York, Massachusetts, West Virginia, Delaware). The measure is also being used at the provider-level in Centers for Medicare and Medicaid (CMS) behavioral health home demonstrations; however, it has not been endorsed at the provider level (CMS, 2019).

**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.

We tested the measure using 2014 Medicaid Analytic Extract (MAX) data on 9398 SUD service providers (including both individual providers and facilities/group practices) that treated at least ten patients with an OUD diagnosis. The number of beneficiaries only eligible for Medicaid (not both Medicaid and Medicare) with at least one medical claim for an encounter with a primary or secondary OUD diagnosis in the calendar year was 716,431. The mean provider-level score was 38.4% with provider-level scores ranging from 0% to 100%. Below we present the provider-level score distribution.

#### Summary Data of Observed Scores

n	Mean	SD	Min	10th	25th	50th	75th	90th	Max
All Provider Types									
9398	38%	33%	0%	0%	10%	28%	66%	92%	100%
Individual Clinicians									
5344	44%	35%	0%	0%	10%	37%	79%	93%	100%
Hospitals/Facilities/Agencies									
4054	31%	28%	0%	3%	9%	22%	45%	80%	100%

**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.**

Not applicable

**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.

There are disparities in the use of medications to treat opioid use disorder as revealed in the table below. The table describes the percentage of patients diagnosed with an opioid use disorder who received medications to treat opioid use disorder by gender and race. Men are less likely to receive medications than women. Blacks are less likely to receive medications than Whites.

Hispanics/Latinos are more likely to receive medications than Whites or Blacks.

	Mean	N
Gender		
Male	43%	368,554
Female	48%	347,877
Total	46%	716,431
Race		
White	49%	463,846
Black	31%	68,414
American Indian/Alaskan Native	50%	7,290
Asian	42%	2,707
Hispanic/Latino	64%	23,957
Native Hawaiian/Pacific Islander	64%	1,881
Total	46%	716,431

**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**

[Not applicable.](#)

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

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

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

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

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

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

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

[Not applicable](#)

**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:** [Data\\_Dictionary\\_for\\_MAT\\_Receipt\\_Measure\\_\\_7-9-20.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.

**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.

[Not applicable.](#)

**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).

Beneficiaries ages 18 to 64 with an OUD who filled a prescription for, or were administered or ordered, an FDA-approved medication for the treatment of OUD within 30 days of the first attributable encounter with an OUD diagnosis with the provider.

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

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

The measure numerator is the number of beneficiaries ages 18 to 64 with an OUD diagnosis ( see Appendix A in Data Dictionary) who filled a prescription for, or were administered or ordered, an FDA-approved medication to treat OUD ( see Appendix B in Data Dictionary) within 30 days of the first attributable encounter with the provider.

Note that the OUD medication administration or prescription can be from any provider (e.g., office-based physician, hospital, OTP), it need not necessarily be the attributed provider. This justification is that all providers who treat patients with an OUD diagnosis should be held accountable for ensuring that they receive gold standard treatment.

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

Number of Medicaid ages 18 – 64 beneficiaries with at least one medical claim for an encounter with an OUD diagnosis with that provider (where the provider is identified by a National Provider Identifier (NPI) code).

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

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

The target population for the denominator includes all Medicaid beneficiaries age 18 through 64 years with a diagnosis of OUD (primary or other) that had an encounter with the provider at least once during the measure time period which is defined as a calendar year. See Appendix A for ICD codes for identifying OUD. Age is calculated as of December 31st of the measurement year. Denominator exclusions are described below in 5.8.

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

Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow up treatment medications (e.g. medication assisted treatment) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore, follow-up would be missed.

Individuals under 18 are excluded. Rationale: There is limited evidence regarding the efficacy of MOUD for this population.

Individuals over 64 are excluded: Rationale: Most individuals over age 64 are covered under Medicare. Services covered by Medicare would not be capture in the Medicaid claims data and therefore follow-up treatment would be missed.

**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.)

Instructions for the analytic file build, including denominator exclusion detail are included below.

Measurement Year: Calendar year 2014

Ages: 18 years and older as of December 31 of the measurement year. 64 or younger as of December 31 of the measurement year

Required Benefits: Medical, Chemical Dependency, and Pharmacy

Analytic File Inclusion Criteria Follow steps below.



<p>1. Subset file to patients who had an OUD diagnosis. (Appendix A contains ICD codes for identifying OUD) in any diagnostic position from any provider during selected Calendar year.</p> <p>2. Eliminate dual eligible (Medicare/Medicaid) beneficiaries.</p> <p>3. Eliminate any patient IDs of patients younger than 18 as of December 31 of the measurement year, or older than 64 as of December 31 of the measurement year.</p> <p>4. Pull all the claims/records from the enrollment, inpatient, outpatient, prescription drug files, and long-term claims files with these Member IDs into an analytic sample.</p>
<p><b>S.10. Stratification Information</b> <i>(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.)</i></p> <p>Not applicable.</p>
<p><b>S.11. Risk Adjustment Type</b> (Select type. Provide specifications for risk stratification in measure testing attachment)</p> <p>No risk adjustment or risk stratification</p> <p>If other:</p>
<p><b>S.12. Type of score:</b></p> <p>Rate/proportion</p> <p>If other:</p>
<p><b>S.13. Interpretation of Score</b> <i>(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)</i></p> <p>Better quality = Higher score</p>
<p><b>S.14. Calculation Algorithm/Measure Logic</b> <i>(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.)</i></p> <p>Identify denominator</p> <p>Identify Medicaid beneficiaries age 18 through 64 years with at least one encounter with a provider with an OUD diagnosis on the claim (primary or other secondary) during the measurement year. Must be continuously enrolled for at least 30 days after the attributable encounter . Age is calculated as of December 31st of the measurement year.</p> <p>Step 1. Identify the attribution date, the first encounter between a member and a provider. The attribution date is as follows.</p> <p>a. Outpatient Encounter Attribution Date: Attribution date is the date of the encounter with an outpatient provider that includes an OUD diagnosis (primary or secondary).</p> <p>b. Inpatient/Residential Encounter Attribution Date. Attribution date is the discharge date from an inpatient/residential provider that includes an OUD diagnosis (any position).</p> <p>Note: a member can be attributed to more than one provider at different times during the measurement period. However, if members have multiple attribution dates with a single provider, only the first is included in the denominator.</p> <p>Step 2. Exclude a member from the denominator for a provider organization if the attribution date is after December 1 to allow for 30 days of time after the encounter.</p> <p>Step 3. Only include members with continuous enrollment over the relevant 30 day time period.</p> <p>Step 4. Exclude providers if their total number of attributable members is &lt; 10.</p> <p>Step 5. Count the number of patients in the denominator with a qualifying_medication_event_date (Appendix B) &lt;= 30 days of the attribution_date (attribution_date &lt;= qualifying_medication_event_date &lt;= attribution_date + 30 days)</p> <p>Step 6. Report measure metrics at the NPI level separately for individual clinicians and hospitals/agencies/facilities.</p>
<p><b>S.15. Sampling</b> <i>(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</i></p> <p>IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.</p> <p>Not applicable. The measure is not based on a sample.</p>

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

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

Not applicable. The measure is not based on survey or patient-reported data.

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

If other, please describe in S.18.

Claims, Enrollment Data

**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.

The data source is Medicaid Analytic Extract (MAX) files, including person summary (PS), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. The Medicaid Analytic Extract (MAX) files contain data from 32 states.

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

No data collection instrument provided

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

Clinician : Individual, Facility

**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.)

Not applicable.

## 2. Validity – See attached Measure Testing Submission Form

MAT\_Receipt\_Attribution\_Appendix\_7\_13\_20.docx, MOUD\_Receipt\_Testing\_Form\_092720.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.

### 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.

### 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.



### 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).

**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.

Not applicable.

**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).**

None.

### 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)
	<p>Quality Improvement (external benchmarking to organizations) New York, Massachusetts and West Virginia Medicaid <a href="https://www.treatmentatlas.org/">https://www.treatmentatlas.org/</a></p> <p>Quality Improvement (Internal to the specific organization) New York, Massachusetts and West Virginia Medicaid <a href="https://www.treatmentatlas.org/">https://www.treatmentatlas.org/</a></p>

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

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

•Name of program and sponsor: New York Office of Addiction Supports and Services, Shatterproof ATLAS, a related measure is being used as part of the CMS Medicaid Adult and Home Core Sets Program.

•Purpose: Quality Improvement

•Geographic area and number and percentage of accountable entities and patients included: New York state (approximately 274 addiction treatment facilities), Shatterproof ATLAS (approximately 400 addiction treatment providers across 4 states, New York, Massachusetts, Delaware, and West Virginia).

•Level of measurement and setting: Provider of addiction treatment.

**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?)

Not applicable.

**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.)

Not applicable.

**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.**

All Medicaid participating substance use disorder specialty facilities in New York, New York, Massachusetts, West Virginia, and Delaware (approximately 400 facilities).

**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.**

The data are presented in a portal only accessible to providers, state policymakers, and providers. Providers are offered technical

assistance material and training to help expand access to MOUD

**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.**

The measure was developed with feedback from state Medicaid programs, commercial health plans, addiction treatment providers, patients, families, and other experts. Experts reviewed the measure as part of a NQF sponsored Strategy session. Focus groups were held with providers, patients, and families to obtain feedback on the measures. One Medicaid program and one commercial health plan helped to test and refine the initial specification. The measure was then implemented by four Medicaid programs as part of Shatterproof Atlas. New York State's Office of Addiction Supports and Services has integrated the measure into its quality improvement activities

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

Not applicable.

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

Not applicable.

**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.**

Not applicable.

#### **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.**

Despite the clear benefits of MOUD, many practitioners do not offer them to their patients with OUD. In 2018, only 40% of specialty addiction treatment facilities offered medications to treat opioid use disorder (Mark et al., 2020) and many regions of the county lack adequate supply of buprenorphine waived professionals (Abraham et al., 2020, Andria et al., 2020). A 2014 American Society of Addiction Medicine expert panel recommended that the Use of Pharmacotherapy Measure (NQF #3400) be created as a measure at the clinician level (ASAM, 2014). They note that individual providers use measures for internal quality improvement and to monitor their practices (ASAM, 2014). NQF endorsed Use of Pharmacotherapy (NQF #3400) – a measure of percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for opioid use disorder (MOUD) during the measure year - at the health plan/Medicaid program level. However, this measure is not useful for individual providers who would like to evaluate their use of OUD medications in their patient population because it is defined at the health plan/Medicaid program level. Developing a measure at the provider/clinician level will help to identify opportunities to improve OUD treatment.

The results of the testing of this measure indicate significant opportunities for improvement. The mean provider-level score was 38.4% with provider-level scores ranging from 0% to 100%.

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#### **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.**

This measure has not been implemented yet. There were no unexpected findings identified during testing of this measure.

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

This is a new measure that has not been implemented yet. No unexpected benefits were observed during testing.

## 5. Comparison to Related or Competing Measures

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

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

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

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

3175 : Continuity of Pharmacotherapy for Opioid Use Disorder

3400 : Use of Pharmacotherapy for Opioid Use Disorder (OUD)

#### 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?

Yes

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

The measure is harmonized with NQF3400: Use of Pharmacotherapy for Opioid Use Disorder (OUD). The same OUD code and pharmacotherapy codes are included in both. The differences between NQF 3400 and this measure (Prescription or administration of pharmacotherapy to treat OUD), is that this measure is meant to be used at the provider level. Therefore, this measure has processes to identify providers and attribute patients with OUD to them. The measure is harmonized with NQF3400: Use of Pharmacotherapy for Opioid Use Disorder (OUD). The same OUD code and pharmacotherapy codes are included in both. The differences between NQF 3400 and this measure (Prescription or administration of pharmacotherapy to treat OUD), is that this measure is meant to be used at the provider level. Therefore, this measure has processes to identify providers and attribute patients with OUD to them.

### 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.)

Not applicable.

## Appendix

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

**Attachment** **Attachment:** [MOUD\\_Receipt\\_Attribution\\_Appendix\\_10\\_29\\_2020.docx](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** RTI International

**Co.2 Point of Contact:** Tami, Mark, [tmark@rti.org](mailto:tmark@rti.org), 240-636-2410-

**Co.3 Measure Developer if different from Measure Steward:** RTI International

**Co.4 Point of Contact:** Tami, Mark, [tmark@rti.org](mailto:tmark@rti.org), 301-636-2410-

## Additional Information

### Ad.1 Workgroup/Expert Panel involved in measure development

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

An expert panel, supported by NQF, was assembled as a part of a day long Quality Innovation Measuring Quality of Care in Substance Use Disorder (SUD) Treatment Programs Strategy Session.

The meeting objectives included discussion of considerations for measuring quality of care for purposes of rating substance use disorder (SUD) treatment programs, gathering feedback on the proposed measure, provision of guidance for adapting the measure for use at the facility-level and aligning with related measures.

Expert panel members included the following:

Jennifer B. Atkins, MBA

Vice President, Network Solutions, Blue Cross Blue Shield Association

Ellen Bouchery, MS

Principal Program Analyst, Mathematica Policy Research

Teresita Camacho-Gonsalves, PhD, MA

Co-Director of Behavioral Health Team, Human Services Research Institute

Vitka Eisen, EdD, MSW

President & CEO, HealthRight 360

Joseph Lee, MD

Medical Director, Hazelden Betty Ford Foundation Youth Continuum

Miriam Komaromy, MD, FACP, DFASAM

Professor of Medicine, Director of Addiction and Community Health Worker Programs at the ECHO Institute, University of New Mexico Health Sciences Center

Tami Mark, PhD, MBA

Senior Director, Behavioral Health Financing and Quality Measurement, RTI International

Tiffany McCaslin, MPP

Senior Policy Analyst, Public Policy, National Business Group on Health

Thomas McLellan, PhD

Founder, Treatment Research Institute

Kirk Moberg, MD, PhD, FASAM, FACP, FAAPL, CPE

Executive Medical Director, UnityPoint Health Illinois Institute for Addiction Recovery

Douglas Nemecek, MD, MBA

Chief Medical Officer – Behavioral Health, and National Medical Officer – Coverage Policy and Trend Review, Cigna

Andre Ostrovsky, MD

Chief Executive Officer, Concerted Care Group

Justin Luke Riley, MBA

President & CEO, Young People in Recovery  
 Patricia Santora, PhD  
 Public Health Analyst, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Service Administration (SAMHSA)  
 Sarah Wattenberg, MSW  
 Director of Quality and Addiction Services, National Association of Behavioral Healthcare

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

**Ad.2 Year the measure was first released:** 2020

**Ad.3 Month and Year of most recent revision:** 10, 2020

**Ad.4 What is your frequency for review/update of this measure?** Annually

**Ad.5 When is the next scheduled review/update for this measure?** 10, 2021

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