



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 #: 3389

Corresponding Measures:

De.2. Measure Title: Concurrent Use of Opioids and Benzodiazepines (COB)

Co.1.1. Measure Steward: PQA, Inc.

De.3. Brief Description of Measure: The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.

A lower rate indicates better performance.

1b.1. Developer Rationale: Overdose deaths involving prescription opioids were five times higher in 2106 than in 1999, and more than 200,000 people have died in the U.S. from overdoses related to prescription opioids.(1,2) Scientific research has identified high-risk prescribing practices that have contributed to the opioid overdose epidemic, including overlapping opioid and benzodiazepine prescriptions.(3) Concurrent use of opioids and benzodiazepines, both central nervous system (CNS) depressants, increases the risk for severe respiratory depression, which can be fatal.(3,4)

According to the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016, clinicians should avoid concurrent prescribing of opioids and benzodiazepines whenever possible.(3) This is a Category A recommendation (applies to all persons; most patients should receive the recommended course of action) and is based on Type 3 evidence (observational studies or randomized clinical trials with notable limitations). In August 2016, the US Food and Drug Administration added concurrent use of opioids and benzodiazepines as a black box warning to prescription opioids (analgesic and cough medicine) and benzodiazepines.(4)

Several studies indicate that concurrent use of opioids and benzodiazepines puts patients at greater risk for a fatal overdose. Three studies of opioid overdose deaths found evidence of concurrent benzodiazepine use in 31%–61% of cases.(5-7) In the United States, the number of opioid overdose deaths involving benzodiazepines increased 14% on average for each year from 2006 through 2011. However, the number of opioid overdose deaths not involving benzodiazepines did not change significantly.(8) A case-cohort study found that concurrent use of benzodiazepines among US veterans raised the risk of drug overdose deaths four-fold (hazard ratio, 3.86, 95% confidence interval [CI] 3.49-4.26) compared with patients not using benzodiazepines.(9) In a large sample of privately insured patients from 2001-2013, opioid users who also used benzodiazepines were at substantially higher risk of an emergency department (ED) visit or hospital admission for opioid overdose (adjusted odds ratio 2.14; 95% CI, 2.05-2.24). If this association is causal, elimination of the concurrent use could reduce the population risk of an ED visit or hospitalization for opioid overdose by 15%.(10)

Despite the risks, concurrent prescriptions for opioids and benzodiazepines are common and increasing. From 2001-2013, concurrent prescribing (overlap of at least one day) increased by nearly 80% (from 9% to 17%) among privately insured patients.(10) In one study, approximately half of the patients received both opioid and benzodiazepine prescriptions from the same prescriber on the same day.(11) In a 2015 analysis of Medicare Part D non-cancer and/or non-hospice patients on opioid therapy, the prevalence of benzodiazepine concurrent use was 24%.(12)

The PQA Concurrent Use of Opioids and Benzodiazepines measure evaluates a process that correlates with increased risk of opioid overdose. Efforts to prevent opioid overdose deaths should include a multi-faceted approach, including strategies that focus on monitoring and reducing opioid prescribing that has an unfavorable balance of benefit and harm for most patient populations. The measure excludes patients with cancer and those in hospice due to the unique therapeutic goals, ethical considerations, increased

opportunities for medical supervision, and balance of risks and benefits with opioid therapy.(3)

1. Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017/ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at <http://wonder.cdc.gov>
2. Frenk SM, Porter KS, Paulozzi LJ. Prescription opioid analgesic use among adults: United States, 1999–2012. NCHS data brief, no 189. Hyattsville, MD: National Center for Health Statistics. 2015.
3. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. MMWR Recomm Rep. 2016;65(1):1-49. doi:10.15585/mmwr.rr6501e1.
4. US Food and Drug Administration. FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning. August 31, 2016. Available at: <http://www.fda.gov/Drugs/DrugSafety/ucm518473.htm>. Accessed: November 9, 2016.
5. Gomes T, Mamdani MM, Dhalla I a, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. Arch Intern Med. 2011;171(7):686-691. doi:10.1001/archinternmed.2011.117.
6. Dasgupta N, Funk MJ, Proescholdbell S, Hirsch A, Ribisl KM, Marshall S. Cohort Study of the Impact of High-dose Opioid Analgesics on Overdose Mortality. Pain Med. September 2015. doi:10.1111/pme.12907.
7. Jones CM, McAninch JK. Emergency Department Visits and Overdose Deaths From Combined Use of Opioids and Benzodiazepines. Am J Prev Med. 2015;49(4):493-501. doi:10.1016/j.amepre.2015.03.040.
8. Chen LH, Hedegaard H, Warner M. Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999-2011. NCHS Data Brief. 2014;(166):1-8.
9. Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert ASB. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics?: case-cohort study. :1-8. doi:10.1136/bmj.h2698.
10. Sun EC, Dixit A, Humphreys K, et al. Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis. BMJ. 2017;356:j760. doi: 10.1136/bmj.j760. PMID: 28292769
11. Hwang CS, Kang EM, Kornegay CJ, Staffa JA, Jones CM, McAninch JK. Trends in the Concomitant Prescribing of Opioids and Benzodiazepines, 2002-2014. Am J Prev Med. 2016;1-10. doi:10.1016/j.amepre.2016.02.014.
12. CMS. Concurrent Use of Opioids and Benzodiazepines in a Medicare Part D Population. May 12, 2016. 2016. <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Concurrent-Use-of-Opioids-and-Benzodiazepines-in-a-Medicare-Part-D-Population-CY-2015.pdf>. Accessed December 6, 2016.

S.4. Numerator Statement: The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

S.6. Denominator Statement: The denominator includes individuals 18 years and older with 2 or more prescription claims for opioid medications on different dates of service and with 15 or more cumulative days' supply during the measurement year. Individuals in hospice, or with a cancer or sickle cell disease diagnosis, are excluded.

S.8. Denominator Exclusions: Individuals in hospice, or with a cancer or sickle cell disease diagnosis at any point during the measurement year are excluded from the denominator.

De.1. Measure Type: Process

S.17. Data Source: Claims, Enrollment Data

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Oct 26, 2018 **Most Recent Endorsement Date:** Oct 26, 2018

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

[Evidence_Submission_Form_-_PQA_COB_FV-636579943284279616.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.

Overdose deaths involving prescription opioids were five times higher in 2106 than in 1999, and more than 200,000 people have died in the U.S. from overdoses related to prescription opioids.(1,2) Scientific research has identified high-risk prescribing practices that have contributed to the opioid overdose epidemic, including overlapping opioid and benzodiazepine prescriptions.(3) Concurrent use of opioids and benzodiazepines, both central nervous system (CNS) depressants, increases the risk for severe respiratory depression, which can be fatal.(3,4)

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 5. Gomes T, Mamdani MM, Dhalla I a, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. Arch Intern Med. 2011;171(7):686-691. doi:10.1001/archinternmed.2011.117.
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 12. CMS. Concurrent Use of Opioids and Benzodiazepines in a Medicare Part D Population. May 12, 2016. 2016. <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Concurrent-Use-of-Opioids-and-Benzodiazepines-in-a-Medicare-Part-D-Population-CY-2015.pdf>. Accessed December 6, 2016.

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

The measure was tested in two different health plan data sources – the Medicare and the Medicaid populations.

For the Medicare population, data used for testing came from the Medicare 5% national sample using data from January 1, 2015 to December 31, 2015. The analysis included 710 Medicare Advantage Prescription Drug plans (MA-PD) and 73 standalone Prescription Drug Plans (PDPs) covering 2,952,360 individuals aged 18 and older.

The Medicare rates ranged from 2.1% (minimum) to 44.7% (maximum). The mean rate was 22.2% with a standard deviation of 7.3%. The 25th percentile was 17.4%, the 50th percentile (median) was 21.4% and the 75th percentile was 27.3%. The interquartile range was 9.9%.

For the Medicaid population, the majority of testing data came from the National Medicaid Analytic eXtract (MAX) data. The data included 322 health plans from 17 states covering 11,745,722 individuals aged 18 and older. In addition, one state Medicaid program with three state-based health plans covering 222,896 individuals 18 years and older was included in the testing using the state's Medicaid administrative claims database.

The Medicaid rates for the national (MAX) data ranged from 0.0% (minimum) to 17.3% (maximum). The mean was 5.0% with a standard deviation of 3.5%. The 25th percentile was 2.4%, the 50th percentile (median) was 4.5% and the 75th percentile was 6.9%. The interquartile range was 4.5%.

For the one state Medicaid program with the three health plans, the rate ranged from 2.8% to 6.3%.

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.

N/A

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.*

Disparities data are available for the Medicare population. The testing for the Medicare population came from the Medicare 5% national sample using data from January 1, 2015 to December 31, 2015. The analysis included 710 Medicare Advantage Prescription Drug plans (MA-PD) and 73 standalone Prescription Drug Plans (PDPs) covering 2,952,360 individuals aged 18 and older.

The beneficiary level Low-Income Subsidy (LIS) variable was used to determine disparities in rates for populations with different sociodemographic status. The LIS is a subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. The measure rate for the LIS group was 29.9% while the rate for the non-LIS population was significantly lower, at 19.9%.

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

N/A

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.)

<https://pqaalliance.org/measures/default.asp>

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:

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.

Although we are providing annual updates only, as the measure is not yet scheduled for endorsement maintenance, we outline the important changes since the last update, below.

These specifications have been updated to include a new denominator exclusion for individuals with a diagnosis of sickle cell disease. This change is based on feedback received from measure users, expert input, review and recommendations from PQA's Measure Update Panel, and PQA's Quality Metrics Expert Panel's approval of the exclusion recommendation. Individuals with sickle cell disease have unique pain management needs, and the Centers for Disease Control have stated that their Guideline for Prescribing Opioids for Chronic Pain is not intended to apply to patients with sickle cell disease [Available at <https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2019-CDC-Opioid-Guideline-Clarification-Letter-to-ASCO-ASH-NCCN.pdf>]. Due to these considerations, and their unique therapeutic goals, ethical considerations, opportunities for medical supervision, and balance of risks and benefits, individuals with a diagnosis of sickle cell disease are excluded from this measure.

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).

The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

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 number of individuals from the denominator with:

- 2 or more prescription claims for any benzodiazepine with different dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

Complete the steps below to identify individuals with concurrent use of opioids and benzodiazepines:

Step 1: From the denominator population, identify individuals with 2 or more prescription claims with different dates of service for any benzodiazepine (Table COB-B, below) during the measurement year.

Step 2: Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioid and benzodiazepine prescriptions during the measurement year.

- Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the count of days during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days' supply and overlap that occur after the end of the measurement year.

Note:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 3: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator.

Table COB-B: Benzodiazepines:

Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam

(note: includes combination products; excludes injectable formulations)

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

The denominator includes individuals 18 years and older with 2 or more prescription claims for opioid medications on different dates of service and with 15 or more cumulative days' supply during the measurement year. Individuals in hospice, or with a cancer or sickle cell disease diagnosis, are excluded.

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 denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioid medications on different dates of service and with 15 or more days' supply during the measurement year. Use Table COB-A: Opioids, below, to identify the opioid medications for the measure.

Complete the steps below to determine the denominator:

Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria.

- To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2).

Step 4: Of those identified in step 3, identify individuals with 2 or more prescription claims for opioids on different dates of service, and with 15 or more cumulative days' supply during the measurement year. Exclude days' supply that occur after the end of the measurement year.

Note:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Step 5: Exclude individuals with any of the following during the measurement year:

- Hospice

- Cancer diagnosis
- Sickle cell disease diagnosis

Table COB-A: Opioids:

Benzhydrocodone, buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol

(Note: Includes combination products and prescription opioid cough medications. Excludes the following: injectable formulations; sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine(R) Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

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

Individuals in hospice, or with a cancer or sickle cell disease diagnosis at any point during the measurement year are excluded from the denominator.

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.)*

Hospice exclusion: Exclude any individual in hospice care at any time during the measurement year. Individuals in hospice are identified based on:

- Hospice indicator from the enrollment database, if available (e.g. Medicare); or
- One or more claims with place of service code 34 during the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)

Cancer exclusion: Exclude any individuals with cancer during the measurement year. Individuals with cancer are identified based on:

- One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year. See file titled, PQA Cancer And Sickle Cell Value Sets 2019 and attached in S.2b.
- Pharmacy Hierarchical Condition Category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available. RxHCCs are available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>

Sickle Cell Exclusion: Exclude any individuals with one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year. Refer to SCD ICD codes listed in the file titled, PQA Cancer And Sickle Cell Value Sets 2019.

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 measure is stratified by the following lines of business for the health plan:

- Commercial
- Medicare
- Medicaid

Medicare Plans are further stratified by Low-Income Subsidy (LIS) status.

LIS is a subsidy paid by the Federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their State Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify LIS status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully-subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

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 = Lower 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.)

A. Target population (denominator):

Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

Step 2: Of those identified in step 1, identify individuals meeting the continuous enrollment criteria.

- To be continuously enrolled, an individual may have no more than one gap in enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals where the earliest prescription for an opioid (i.e. Index Prescription Start Date [IPSD]) is 30 or more days from the last day of the measurement year (January 1 through December 2).

Step 4: Of those identified in step 3, identify individuals with 2 or more prescription claims for opioids on different dates of service, and with 15 or more cumulative days' supply during the measurement year. Exclude days' supply that occur after the end of the measurement year.

Note:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Step 5: Exclude individuals with any of the following during the measurement year:

- Hospice
- Cancer diagnosis
- Sickle cell disease diagnosis

Individuals in hospice are identified based on:

- Hospice indicator from the enrollment database, if available (e.g. Medicare); or
- One or more claims with place of service code 34 during the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)

Individuals with cancer are identified based on:

- One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year. See file titled, PQA Cancer And Sickle Cell Value Sets 2019 and attached in S.2b.
- Pharmacy Hierarchical Condition Category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available. RxHCCs are available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html>

Sickle Cell Exclusion: Exclude any individuals with one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year. Refer to SCD ICD codes listed in the file titled, PQA Cancer And Sickle Cell Value Sets 2019.

Step 6: Exclude individuals in hospice, or with a cancer or sickle cell disease diagnosis (Step 5) from those identified in Step 4. This is the denominator.

B. Numerator Population:

Step 7: From the denominator population (from Step 6), identify individuals with 2 or more prescriptions claims with different dates of service for any benzodiazepine during the measurement year.

Step 8: Of the population identified in Step 7, determine the total days of overlap (concurrent use) between the opioids and benzodiazepines prescription claims during the measurement year.

- Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the count of days during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days' supply and overlap that occur after the end of the measurement year.

NOTE:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 9: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator.

C. Measure Rate:

Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage.

- Report the rates separately by line of business (e.g. Medicare, Medicaid, Commercial). For Medicare, report rates for low-income subsidy (LIS) and non-LIS populations separately.

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, 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.

Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs)

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)

Other: The level of analysis for this measure is the prescription drug health plan, but it contains claims data from multiple care settings, including ambulatory, skilled nursing facility, pharmacy etc.

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.)

N/A

2. Validity – See attached Measure Testing Submission Form

Measure_Testing_Form_-_PQA_COB_FV-636579943734123366.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), Other

If other: Medical claims data, Prescription claims data, Prescription Drug Hierarchical Condition Categories (RxHCCs)

3b. Electronic Sources

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

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

ALL data elements are in defined fields in electronic claims

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

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.

Pilot test sites indicated the measure was feasible and results were able to be reported efficiently, accurately, and without difficulty. The required data (prescription claims and medical claims) are readily available.

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).

PQA retains the rights to the measures and can rescind or alter the measures at any time. PQA may approve an organization's use of the measures; however, no organization may use the measures without first obtaining permission from PQA prior to using the measures. Certain uses of the measures are only approved with a licensing agreement from PQA that specifies the terms of use and the licensing fee. PQA reserves the right to determine the conditions under which it will approve use and/or license the measures. Users of the measures shall not have the right to alter, enhance, or otherwise modify the measures.

National Drug Code and ICD code value sets are required to calculate the measure and are provided with the narrative specifications to licensees.

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)

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

Program name & sponsor: Centers for Medicare & Medicaid Services (CMS) Medicaid Adult Core Measure Set. National program with state-level voluntary reporting.

Purpose: The Affordable Care Act (Section 1139B) requires the Secretary of Health & Human Services (HHS) to identify and publish a core set of health care quality measures for adult Medicaid enrollees. The core set is published for voluntary use by state Medicaid programs. State data derived from the core measures are part of CMS's annual Child and Adult Core Set measure reporting, which includes publication of datasets that highlight publicly reportable measures. CMS annually releases information on state progress in reporting the Adult Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality.

Geographic area: This is a national program with state-level reporting.

Level of measurement and setting: Health plan level of measurement. Outpatient setting.

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?)

This is a new measure that was developed in 2016. The measure was added to the 2018 Medicaid Adult Core Measure Set; however, measures in the program are publicly reported only if 25 or more states report on the measure. Given that 2018 is the first year the measure is included, it is not yet publicly reported. We would anticipate adoption of the measure over time, with public reporting once 25 or more states are reporting on the measure.

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.)

The measure has been added to the Medicaid Adult Core Set for 2018. CMS annually releases information on state progress in reporting the Adult Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality.

PQA not only develops and stewards its measures, it also dedicates resources to outreach and implementation efforts. PQA disseminates information regarding the availability of its measures, and provides technical assistance to those implementing or considering implementing PQA-endorsed measures.

Additionally, per the CMS Advance Notice of Methodological Changes for Calendar Year 2019 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2019 Draft Call Letter (available: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Advance2019Part2.pdf>), CMS proposes to begin reporting the Concurrent Use of Opioids and Benzodiazepines measure in the Medicare Part D Patient Safety reports for the 2018 measurement year, and to add it to the Medicare Part D display page for 2021 (using 2019 data) and 2022 (using 2020 data). CMS also will consider this measure for the 2023 Star Ratings (using 2021 data) pending rulemaking.

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.

This measure is been reported to Medicare Part D plan sponsors since 2018 in the monthly Patient Safety reports via CMS' vendor, Acumen. The measure has also been in the Medicaid Adult Core set since 2018 with technical assistance provided by CMS' vendor Mathematica. As measure steward, PQA provides timely technical assistance to questions sent via email to an email box, as well as

questions received via phone or other channels.

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.

This measure is been reported to Medicare Part D plan sponsors since 2018 in the monthly Patient Safety reports via CMS' vendor, Acumen. The measure has also been in the Medicaid Adult Core set since 2018 with technical assistance provided by CMS' vendor Mathematica. As measure steward, PQA provides timely technical assistance to questions sent via email to an email box, as well as questions received via phone or other channels.

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.

N/A

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

N/A

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

N/A

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.

N/A

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.

The performance results can be used to establish benchmarks and identify opportunities to decrease co-prescribing of opioid and benzodiazepines. Sun et al. estimated that the elimination of the concurrent use of opioids and benzodiazepines could reduce the population risk of an emergency department visit or hospital admission for opioid overdose by 15%.(1) Despite the risks, concurrent prescriptions for opioids and benzodiazepines are relatively common and increasing. From 2001-2013, concurrent prescribing increased by nearly 80% (from 9% to 17%) among privately insured patients.(1) In one study, approximately half of the patients received both opioid and benzodiazepine prescriptions from the same prescriber on the same day.(2) In a 2015 analysis of Medicare Part D non-cancer and/or non-hospice patients on opioid therapy, the prevalence of benzodiazepine concurrent use was 24%.(3)

1. Sun EC, Dixit A, Humphreys K, et al. Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis. *BMJ*. 2017;356:j760. doi: 10.1136/bmj.j760. PMID: 28292769
2. Hwang CS, Kang EM, Kornegay CJ, Staffa JA, Jones CM, McAninch JK. Trends in the Concomitant Prescribing of Opioids and Benzodiazepines, 2002-2014. *Am J Prev Med*. 2016;1-10. doi:10.1016/j.amepre.2016.02.014.
3. CMS. Concurrent Use of Opioids and Benzodiazepines in a Medicare Part D Population. May 12, 2016. 2016. <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Concurrent-Use-of-Opioids-and-Benzodiazepines-in-a-Medicare-Part-D-Population-CY-2015.pdf>. Accessed December 6, 2016.

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.

N/A

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.

Yes

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

2940 : Use of Opioids at High Dosage in Persons Without Cancer

2950 : Use of Opioids from Multiple Providers in Persons Without Cancer

2951 : Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

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

Related measures:

- Use of Opioids at High Dosage (NCQA)
- Use of Opioids from Multiple Providers (NCQA)

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 PQA opioid measures (NQF # 2940, 2950, and 2951) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The NCQA opioid measures were developed as an adaptation to existing PQA measures; the NCQA opioid measure denominators are similar to the PQA opioid measures, but have a different area of focus than the concurrent use of opioids and benzodiazepines measure.

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

There are no competing measures (i.e., those that addresses both the same measure focus and the same target population).

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): PQA, Inc.

Co.2 Point of Contact: Lynn, Pezzullo, LPezullo@PQAalliance.org, 401-474-9706-

Co.3 Measure Developer if different from Measure Steward: PQA, Inc.

Co.4 Point of Contact: Lynn, Pezzullo, LPezullo@PQAalliance.org, 401-474-9706-

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.

A diverse group of stakeholders, including health plans and PBMs (those organizations that will be measured) were well represented throughout the entire development process, including contributing to defining the specifications as members of the Measure Development Team, as testers using the measure specifications to calculate the rates, in the review for face validity and review of testing results as members of the Quality Metrics Expert Panel, and in the vote for PQA endorsement.

PQA Measure Development Teams are small, technically proficient teams composed of diverse stakeholders, to develop individual metrics. Measure Development Team 13 (MDT 13) developed the Concurrent Use of Opioids and Benzodiazepines measure. The members of MDT 13 and their corresponding organizations are listed below:

Cyndi Barham, PharmMD

Maribeth Bettarelli, CVS Health

Donna Boreen, BCBSMN

Jeffrey Bratberg, University of Rhode Island College of Pharmacy (representing the American Association of Colleges of Pharmacy)

Sara Burnheimer, UPMC Health Plan

Pauline Chan, California Department of Health Care Services

Alexandra Cruz, Healthfirst

Samuel Currie, Horizon NJ Health (representing the Association for Community Affiliated Plans)

Tiffany Del Rosario, SCAN Health Plan

Angela DeVeaugh-Geiss, Purdue Pharma LP

Jeff Fink, Express-Scripts

Rainelle Gaddy, Humana

Travis Gau, Medication Management Solutions

Adriane Irwin, American Association of Colleges of Pharmacy

Shellie Keast, University of Oklahoma

Richard Logan, MedHere Today

Michael Long, APhA

Denis Matsuoka, Kaiser Permanente

Karen McLin, SinfoniaRx

Alina Meile, Aetna

Mary Miller, Rite Aid

Anna Polk, Centers for Medicare & Medicaid Services

Madeline Ritchie, Aetna (representing the Academy of Managed Care Pharmacy)

Jennifer Shin, OptumRx

Mindy Smith, PrescribeWellness

Jennifer Snyders, Cigna-HealthSpring

Kathleen Vest, Midwestern University Chicago College of Pharmacy

PQA's Measure Validity Panel (MVP) is a small group of individuals appointed by PQA staff, to determine whether the performance scores resulting from the measure can be used to distinguish good from poor quality clinical care (i.e., validity). The MVP members that reviewed the Concurrent Use of Opioids and Benzodiazepines measure and their corresponding organizations are listed below:

Susan Skledar, University of Pittsburgh
 Ben Banahan, University of Mississippi
 Jeff Pohler, University of FL College of Pharmacy
 Dan Rehrauer, HealthPartners
 Kyle Null, Takeda
 Marybeth Farquhar, URAC

PQA's Quality Metrics Expert Panel (QMEP) is a small group of individuals, selected by PQA staff through an application process, to recommend measure concepts for testing, review measure testing results, and recommend measures for endorsement consideration by PQA membership. The QMEP members that reviewed the Concurrent Use of Opioids and Benzodiazepines measure and their corresponding organizations are listed below:

Amanda Brummel, Fairview Health Services
 Bimal Patel, MedImpact
 Catherine Coast, Highmark
 Christopher Dezii, Bristol-Myers Squibb Company
 Christopher Powers, Centers for Medicare & Medicaid Services
 Craig Schilling, Optum
 David Nau, Pharmacy Quality Solutions
 Gary Erwin, Omnicare
 Jenny Weber, Humana
 Jessica Frank, OutcomesMTM
 Karen Farris, University of Michigan College of Pharmacy
 Keith Widmer, Express Scripts
 Kent Summers, Astellas
 Lynn Deguzman, Kaiser Permanente, Northern California
 Mary Ann Kliethermes, Midwestern University
 Mitzi Wasik, Aetna
 Pat Gleason, Prime Therapeutics
 Steven Riddle, Wolters Kluwer Health
 Steven Burch, GlaxoSmithKline
 Tony Willoughby, McKesson
 Tripp Logan, Logan and Seiler

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2016

Ad.3 Month and Year of most recent revision: 02, 2018

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? 02, 2019

Ad.6 Copyright statement: Rights Retained by PQA, Inc 2018.

Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: N/A