Behavioral Health and Substance Use, Fall 2019 Cycle: CDP Report

DRAFT REPORT FOR COMMENT
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Executive Summary

Behavioral health comprises both mental health and substance use disorders (SUDs) and represents a key construct of healthcare across the globe, unified by brain-based etiology and behavioral symptomology. A comprehensive annual report of behavioral health prevalence data is found in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health (NSDUH). Results from the 2018 NSDUH indicated that, in the U.S., 19.3 million persons aged 18 or older suffered from an apparent SUD (not including tobacco dependence), and 47.6 million persons aged 18 or older suffered from a mental illness. There were 9.2 million persons aged 18 or older who suffered from both SUD and a mental illness. These numbers jointly suggest that substantive behavioral health disease was evident in at least 57.7 million adult Americans in 2018, or roughly 23 percent of the adult population. This rate is consistent with other epidemiologic studies that have previously revealed the prevalence of behavioral health conditions in the U.S.

The NSDUH from 2018 further discusses an important concern about behavioral healthcare in this country: Only 10.2 percent of persons aged 12 and older with SUDs reported receiving treatment during that year, and only 43.3 percent of persons aged 18 and older with any mental illness reported receiving care for that condition. This gap marked behavioral health pathology and treatment alone represents an unmet need among those with behavioral health conditions.

The review and evaluation of behavioral health measures has long been a priority of NQF, with endorsement for mental health and SUD measures going back more than a decade. At present, there are 42 NQF-endorsed behavioral health measures. The background and description of NQF’s most recent BHSU Standing Committee meeting as well as previous meetings are available on NQF’s project webpage. This Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of behavioral health and substance use services. The Committee’s most recent decision making meeting is detailed in this report, and it includes the evaluation and voting results of measures including the use of physical restraint and seclusion, follow-up after emergency department visits for two newly submitted measures, and five measures undergoing maintenance review against NQF’s standard evaluation criteria. The Committee recommended two new measures for endorsement and three measures for continued endorsement, and the Committee did not reach consensus on two measures.

The Committee recommended the following measures for endorsement:

- **NQF 2800** Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **NQF 2801** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- **NQF 3175** Continuity of Pharmacotherapy for Opioid Use Disorder
- **NQF 3539e** Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
- **NQF 3541** Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

The Committee did not reach consensus on the following measures:

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• **NQF 3492** Acute Care Use Due to Opioid Overdose
• **NQF 3538** All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care

Brief summaries of all seven measures considered during this measurement cycle are included in the body of the report; detailed summaries of the Committee’s discussion and ratings of the criteria for each measure are in Appendix A.
Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of or suffering from mental or addictive disorders—challenges broadly ranging from mood and anxiety disorders, to learning disabilities and substance abuse or dependence (including tobacco dependence). In the United States, over 57 million adults suffer from a discernable behavioral health disorder.\(^1\) This includes more than 11 million persons with the most serious forms of mental illness (SMI) such as schizophrenia, bipolar disorder, major depression. Also, 9.2 million adult persons suffer simultaneously from a mental illness and an SUD. Behavioral disorders cause considerable pain and dysfunction in the U.S. population, so much so that it represents the leading cause of death and disability when compared to other major illness clusters including cancers, circulatory disease (heart disease, stroke, arteriosclerosis), injuries, and kidney disease.\(^2\)

Opioid overdose deaths have recently become a particular concern in the U.S., and data compiled by the U.S. Centers for Disease Control and Prevention placed such deaths at over 47,000 in 2017 alone.\(^{17}\) U.S. suicides in 2016 approach that number,\(^{18}\) and deaths attributable to alcohol use (overdose, accidents, cirrhosis, cancers) numbered approximately 88,000 per 2006-2010 data, thus making alcohol use the third most common cause of preventable mortality behind tobacco use (first) and poor diet and physical inactivity (second).\(^{19}\) Finally, mental illness strongly correlates with premature death by an average of 8 years for all mental illnesses, and 25 years for the most serious forms.\(^{20}\) The causes for this premature mortality are multifactorial including tobacco use, suicide, poor self-advocacy, and risk of victimization, but a least one recent study found that 95 percent of these premature deaths are from medical causes.

There are deep challenges posed by behavioral health illnesses. Such illnesses are typically cycling, chronic, and serious. Nonetheless, there exist many evidence-based approaches to prevent such illnesses and to treat persons and families impacted by them.\(^{21–23}\) Applications of these strategies are neither easy nor universal; however, they are made challenging by the complexity and uncertainty of the underlying pathology and by stigma that shrouds a category of diseases that often negatively impact social functioning.\(^{24–27}\) Accordingly, quality measurement and quality improvement tools are essential to behavioral health.

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

The Behavioral Health and Substance Use Standing Committee (Appendix C) oversees NQF’s portfolio of Behavioral Health and Substance Use measures (Appendix B) that includes measures for serious mental illnesses (e.g., schizophrenia, mania, major depression), dysthymia, anxiety, ADHD and other learning and behavioral problems, alcohol and illegal drug use, tobacco dependence, care coordination (between and within the spheres of psychiatric, substance use, and related physical illness), medication use, and patient care experience. This portfolio contains 42 measures: 35 process measures, six outcome and resource use measures, and one composite measure (see Table 1).

Additional behavioral health measures have been assigned to other portfolios. Examples include patient experience measures (Patient Experience and Function project); measures focused on antipsychotics,
screening for drugs of abuse in psychosis, and tobacco use (Pediatrics/Patient Safety projects); measures related to pharmacotherapy for opioid use disorder (Patient Safety project); unplanned readmissions following psychiatric hospitalization (All-Cause Admissions and Readmissions project); and smoking prevalence (Prevention and Population Health project).

Table 1. NQF Behavioral Health and Substance Use Portfolio of Measures

<table>
<thead>
<tr>
<th>Process</th>
<th>Outcome/Resource Use</th>
<th>Composite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Use</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Depression</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Medication Use</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Experience of Care</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Tobacco</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Physical Health</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

Behavioral Health and Substance Use Measure Evaluation

On January 29 and 31, and February 5, 2020, the Behavioral Health and Substance Use Standing Committee evaluated two new measures and five measures undergoing maintenance review against NQF’s standard measure evaluation criteria.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary

<table>
<thead>
<tr>
<th></th>
<th>Maintenance</th>
<th>New</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measures under consideration</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Measures recommended for endorsement</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Measures where consensus is not yet reached</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on November 26, 2019 and will close on April 9, 2020. As of January 24, 2020, three comments were submitted and shared with the Committee prior to the measure evaluation meeting(s) (Appendix F).

All submitted comments were provided to the Committee prior to its initial deliberations during the web meeting.
Overarching Issues
During the Standing Committee’s discussion of the measures, several overarching issues emerged that were factored into the Committee’s ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Interpretation of Year-Over-Year Improvement Data
In the course of reviewing measure submission criteria related to Usability and Use, the Committee noted that several of the measures did not exhibit significant improvements in year-over-year performance data. Committee members noted that this was difficult to interpret. The Committee regarded this as a potential concern, noting that the purpose behind measurement is not a means unto itself, but rather to improve the quality of care that persons with behavioral health conditions receive. The expectation for a good quality measure is to exhibit responsiveness to improvement efforts. Many measures demonstrate responsiveness to quality improvement efforts, especially during the early stages post implementation. During a measure’s life cycle, it is not uncommon for a measure to become topped out in its performance as good best practices for quality improvement become better disseminated and adopted across healthcare settings.

It was noted that the interpretation of the data related to stagnating improvement is not always simple, and the Committee speculated that improvement deceleration could be due to lack of discernable differences in quality between providers; that the measure is truly capped out in performance; that adequate incentives to address quality challenges have yet to be introduced; or that the behavioral health challenge that the measure intends to address is particularly recalcitrant.

Measure Validity Beyond the Tested Population
During the consideration of measures for endorsement recommendation this cycle, the Committee reviewed several measures that were intended for broader population health applications, such as within state-level dashboards. The measures were noted to have been tested within a particular state, but the Committee noted that the populations of the states where they were tested differ substantially from other U.S. states. This calls into question the applicability of testing results from one state program when considered for a different state, and the potential need to risk-adjust or stratify measure results at a population level in order to perform appropriate comparisons between state-level performances based on these measures.

Summary of Measure Evaluation
The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee’s discussion and ratings of the criteria for each measure are included in Appendix A.

2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics (National Committee for Quality Assurance): Recommended
Description: The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing; Measure Type: Process; Level of Analysis: Health Plan; Setting of Care: Outpatient Services, Emergency Department and Services; Data Source: Claims.
The Standing Committee recommended the measure for continued endorsement. This maintenance measure assesses the percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions who had metabolic testing (i.e., glucose and cholesterol monitoring). Since the last review in 2016, the measure now has separate rates for each metabolic test in addition to the combined rate of receiving both tests. The measure also now combines two of the age strata. The Committee agreed that this metabolic monitoring measure is an important part of managing patient risk and is supported by evidence from guidelines. The Committee encouraged the developer to consider including more recent literature in the evidence presentation for the next submission.

The Committee accepted the results of the score-level reliability and validity testing. There was discussion about whether the measures selected for construct validity, measures of adolescent well-care visits and well-child visits are the appropriate measures to expect strong correlations.

The measure is used by commercial health plans and is in the Medicaid Child Core Set for 2020. Regarding usability, the Committee agreed there is opportunity for improvement, but questioned why there has not been more performance improvement over the past four years. Some members noted that health plans would not be overly challenged to perform well on the measure. The developer shared that splitting out results by testing type may provide better information to inform improvement. Other members expressed that required public reporting may further incentivize improvement.

2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (National Committee for Quality Assurance): Recommended

**Description**: Percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration primary indication for antipsychotics, and had documentation of psychosocial care as first-line treatment; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient services; **Data Source**: Claims.

The Standing Committee recommended the measure for continued endorsement. This maintenance measure assesses the percentage of children aged 1-17 years with a new antipsychotic prescription without an indication who had documentation of psychosocial care as first-line treatment. The developer acknowledged that since 2016, the measure has been updated to combine the two lower-age strata but is otherwise the same.

It was noted there are no new studies that contradict the evidence presented, and several Committee members emphasized that this topic area needs careful attention and monitoring. It was clarified that the measure allows for psychosocial care to be provided up to 30 days after the first prescription. At least one member noted that a strength of the measure is that it appropriately excludes serious mental illness. The Committee agreed there was significant room for improvement, and that score-level reliability and validity testing results supported the measure’s scientific acceptability. Construct validity was performed using four measures that reflect coordinated care across settings.

Regarding use, the measure is publicly reported in various applications. A potential unintended consequence discussed was that there may be other clinical scenarios beyond those included in the

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specifications, in which you would not want to hold off starting medication while trying to help patients enroll in therapy.

The Committee emphasized the need for interventions that generate improvement on this measure, as there was concern that there has not been enough improvement over time. Some members supported a version of this measure in the future that removes the indications and focuses on ensuring all children receive appropriate care coordination and psychosocial support.

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

Description: Percentage of adults of at least 18 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment; Measure Type: Process; Level of Analysis: Clinician: Individual, Group/Practice, Health Plan, Population: Regional and State; Setting of Care: Outpatient Services; Data Source: Claims.

Ad Hoc Review of Scientific Acceptability at the Clinician Level of Analysis

This measure was submitted with a change in level of analysis to include individual clinician-level and group/practice clinician-level testing. As a result, the Committee conducted a targeted review of reliability and validity at the clinician level; criteria beyond reliability and validity were not re-adjudicated during this review. The measure was endorsed in 2017 at the health plan and state levels of analysis. It was presented to the Measure Applications Partnership (MAP) in 2018. MAP encouraged the developer to test the measure at the clinician level of analysis before it is implemented in MIPS. The measure passed reliability and validity at the clinician level based on the new testing provided. The endorsement of this measure is therefore recommended to be expanded to the clinician level of analysis at both the individual and group/practice levels. This measure focuses on the percentage of adults on medications for OUD who have at least 180 days of continuous treatment.

The Committee agreed data collection was very consistent, and the measure has clearly defined exclusions. It agreed that testing results passed the general threshold for reliability. The measure submission noted that two-thirds of an expert panel of nine individuals agreed or strongly agreed that the measure has face validity. The Committee had some concern about the remaining panelists that dissented or were neutral. The developer shared that face validity results presented during the last review also support the measure’s validity. NQF staff reminded the Committee that face validity is acceptable testing for the first evaluation (applicable to the current review) and that empirical testing will be necessary for maintenance review. The Committee generally agreed that the attribution approach presented was thorough and well-developed. The developer added that two-thirds of cases could be attributed to a single provider, and that the “plurality rule” using the days-covered method was also used in attribution.

The Committee discussed the data used for testing and whether the sample was representative of the population in which the measure would be used. The developer clarified that the majority of patients in their testing sample were below 65 years of age and dual eligible, which is representative of the opioid use population. The developer noted they were limited to Medicare Fee-for-Service data for their analysis. It was suggested that using an all-payer database would allow for a larger patient volume per
clinician, and more clinicians would have enough patients to calculate a performance score. It was discussed that the vast majority of the pharmacotherapy included in the measure was for Buprenorphine rather than methadone. The Committee was very interested in reviewing empirical validity testing during the scheduled maintenance review. The measure will retain its existing maintenance review schedule.

**Subtopic Area**

### 3492 Acute Care Use Due to Opioid Overdose (Yale CORE): Consensus Not Reached

**Description:** This is a population measure that indicates the rate of emergency department visits for opioid overdose events in a specified geographic region using ICD-10 diagnosis codes from claims. The outcome is defined as the incidence of overdose events per 1,000 person-years among Medicare beneficiaries greater than 18 years of age residing in the specified geographic region. The measure has been tested for use at both the county and state levels; **Measure Type:** Outcome; **Level of Analysis:** Population: Community, County, or City; Population: Regional and State; **Setting of Care:** Inpatient/Hospital, Outpatient Services, Emergency Department and Services; **Data Source:** Claims.

The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on validity—a must-pass criterion.

This new measure, specified at the population level (county and state), was developed for use in the Maryland Total Cost of Care model. The measure captures the rate of emergency department (ED) visits for opioid overdose among individuals in a specified geography over a one-year period. This measure was rated as low on the validity criterion by NQF’s Scientific Methods Panel (SMP). The SMP concerns stemmed from the narrow scope of data used in testing and the lack of risk adjustment. The SMP also questioned the control of the healthcare sector in influencing the risk of opioid overdose. Although the measure did not pass the SMP, Committee members are able to pull measures for discussion at their discretion if one or more Committee members requests to do so. When a measure doesn’t fail SMP review for a critical reason (e.g., inappropriate testing methodology), the measure is eligible for revote by the Committee. The measure was pulled by a Committee member for discussion and voting.

Regarding evidence, the Committee generally felt that there are obvious interventions that healthcare providers and systems can perform to reduce the risk of opioid overdose such as using medication-assisted treatment (MAT) and safer prescribing practices, increasing the capacity to provide MAT, and enacting mandatory prescription drug monitoring programs. The discussion included the benefit of this measure over the existing indicators of ED utilization and opioid overdose. The developer responded that the measure precisely addresses performance in the Medicare population, the population in which the measure is intended to be used. The Committee emphasized that overdose deaths varied four times across states and 10 times between the lowest- and highest-performing counties.

The Committee agreed that the score-level and data element reliability testing results indicate the measure is reliable. The measure is supported by empirical validity testing that compares performance on the measure to performance on two other related indicators (i.e., opioid-related ED and hospital visits in an all-care population and age-adjusted rate of fatal overdose) in 25 states. Validity testing results showed the measure was highly correlated with the other measures. The Committee expressed...
The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on evidence—a must-pass criterion.

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The developer shared that the new measure is intended for use in state Medicaid to improve quality of care for beneficiaries with physical and mental health integration needs. The denominator includes four strata: beneficiaries with co-occurring physical health and mental health conditions, beneficiaries with co-occurring physical health conditions and an SUD, beneficiaries with co-occurring mental health conditions and a SUD, and beneficiaries with SMI.

Evidence indicates state-level integrated care pilot programs have shown promise in reducing ED use for those with the need for integrated care. The Committee expressed concern that the evidence of the outcome represents true quality of care. The primary concern of the Committee was that the annual ED visit for these populations on a state level may not be strongly linked to the desired quality care outcome, which was integrated physical and behavioral healthcare; it was not clear to some Committee members how one could strongly construe that lower ED utilization equated to higher quality of care. The Committee discussed how this is further complicated by social determinants of health (SDOH) and problems of ED use common to patients with psychiatric conditions. The Committee also called into question the cause-and-effect nature of the logic model, as well as the quality of the evidence presented.

The developer reiterated that the denominator is a unique population, and care coordination and communication are critical to managing these patients appropriately.

The Committee agreed that performance data can lead to multiple downstream outcomes and drive change, but they had some concern that there are factors other than adequate outpatient care and appropriate care coordination, including but not limited to, SDOH that play a significant role in why individuals frequent the ED. It was also noted that adequate use is determined by whether an ED visit results in an observation or inpatient psychiatric stay, but there are shortages of psychiatric inpatient beds available in some places.

The Committee discussed that data from 17 states showed high ED use and opportunity for improvement. In the future, the Committee is interested in reviewing normative rates of ED use or rates by a single diagnosis to better understand the appropriate measure benchmark. The scientific acceptability was reviewed by the SMP; the SMP supported that the measure is reliable and valid. The Committee discussed the impact of SDOH on performance. Some members expressed that social factors could unfairly impact measure rates, but others noted that the measure should not be adjusted in order to fully understand the factors driving results at the state level. The developer acknowledged that social risk factors were not included in the risk adjustment model, but noted that the population is relatively homogeneous and focuses on patients enrolled in Medicaid (a proxy for socioeconomic status).

The Committee agreed that the measure is feasible without additional discussion. The Committee accepted the measure’s planned use to evaluate states and drive improvement in efficient ED use. Additional consideration shared by the Committee include whether there are better intermediate steps between outpatient care and ED visits that should be measured and the potential for unintended consequences (e.g., reducing access to ED care and inappropriately discouraging ED use).
The Committee did not reach consensus on evidence – a must-pass criterion. The Committee will discuss and revote on evidence during the post-comment web meeting on April 22, 2020.

Subtopic Area

3539e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (Mathematica): Recommended

**Description:** Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy; **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Electronic Health Records.

The Standing Committee recommended the measure for NQF endorsement. This new eCQM calculates the proportion of hospitalizations for patients 65 years and older where an antipsychotic medication was prescribed in the absence of the threat of harm to self or others. This measure was originally submitted for NQF endorsement in late 2017. At that time, the Committee recommended additional testing to examine the impact of the exclusions “antipsychotics prior to admission” and “antipsychotics for treatment-resistant depression.”

The evidence for the measure includes the American Geriatrics Society 2019 guidelines and literature that indicates harm from prolonged use of antipsychotics (e.g., higher mortality rate, risk of falls, and cerebral vascular events). Based on testing, the developer decided to exclude patients on antipsychotics prior to admission. The Committee was generally supportive of the added exclusion. One member cautioned that antipsychotics might be warranted in some individuals. The developer reiterated that many patients on antipsychotics for depression would be on these medications before the hospitalization and would be excluded. For performance gap, the Committee agreed data shows too many older patients are receiving these medications.

The reliability discussion focused on whether this measure would capture appropriate on-label prescribing since on-label and off-label indications can vary widely between medications. Overall, the Committee supported the measure’s reliability. Regarding validity and feasibility, the developer noted that the “threat of harm” element is not collected in a structured field systematically across all sites, but increased implementation of the measure would drive better data collection. The Committee voiced that during the maintenance evaluation, they would like to assess whether “threat of harm” is being captured more consistently. The measure was designed for use in the Inpatient Hospital Quality Reporting program. Members commented that a potential unintended consequence of the measure is increased restraint use, but overall, the benefits of the measure outweigh the risks.

NQF staff shared that since this measure is applicable to both the patient safety and behavioral health topic areas, a subset of Patient Safety Standing Committee members was given the opportunity to provide comment. One member shared preliminary comments that generally supported the measure.
Subtopic Area

3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) (Pharmacy Quality Alliance): Recommended

**Description:** The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year; **Measure Type:** Process; **Level of Analysis:** Health Plan; **Setting of Care:** Outpatient Services; **Data Source:** Claims, Enrollment Data

The Standing Committee recommended this new process measure for NQF endorsement. The measure is specified at the health-plan level and captures the percentage of individuals on long-term opioid therapy who failed to receive at least one drug test during the measurement year. The Committee questioned why one test per year was selected as the threshold, and the developer responded that guidelines recommend testing either one or one-to-two times per year. The TEP convened by the developer thought once per year was reasonable, and performance using this requirement indicated a substantial performance gap.

Regarding scientific acceptability, the Committee agreed testing results provided evidence of reliability and validity. The Committee discussed the definition of long-term opioid therapy—90 cumulative days’ supply of any combination of opioid medications indicated for pain. The definition is supported by the literature and aligns with the duration used to define chronic pain. It was noted that, in the future, the developer should explore different methodologies to account for prescriptions filled on the same day, but that it is expected same-day fills minimally impact performance rates.

The measure uses administrative claims data and is intended for use in the Quality Rating System for Qualified Health Plans. Use in other programs in the future, such as Medicare, would require additional testing. At least one member expressed that measurement related to opioid use should move toward more meaningful indicators of safe prescribing, but others emphasized that there is much room for improvement in this area as performance for this measure is very low. One member suggested that emerging drug screening technologies should be included in the future as evidence grows to support the use of such technology. The Committee agreed this measure is valuable and that its benefits outweigh its harms.
References

1 Katz - The National Survey on Drug Use and Health: 2018


4 Mattick et al. - 2014 - Buprenorphine maintenance versus placebo or methad.pdf.
http://unmfm.pbworks.com/w/file/fetch/116281933/Buprenorphine%20or%20methadone%20for%200


6 Subramanian et al. - 2017 - Clozapine dose for schizophrenia.pdf.


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Appendix A: Details of Measure Evaluation

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

Measures Recommended

| 2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics |
|---|---|
| **Submission** | **Specifications** |
| **Description**: The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. |
| **Numerator Statement**: Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year. |
| **Denominator Statement**: Children and adolescents 1-17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions). |
| **Exclusions**: Patients in hospice. |
| **Adjustment/Stratification**: Report two age stratifications and a total rate: |
| • Children and adolescents 1-11 years of age as of December 31 of the measurement year. |
| • Children and adolescents 12-17 years of age as of December 31 of the measurement year. |
| • Total (the sum of the age stratifications). |
| No risk adjustment or risk stratification |
| **Level of Analysis**: Health Plan |
| **Setting of Care**: Emergency Department and Services, Outpatient Services |
| **Type of Measure**: Process |
| **Data Source**: Claims |
| **Measure Steward**: National Committee for Quality Assurance |

STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020

1. Importance to Measure and Report: The measure meets the Importance criteria
(1a. Evidence, 1b. Performance Gap)
1a. Evidence: H-7; M-8; L-0; I-0; 1b. Performance Gap: H-5; M-10; L-0; I-0
Rationale:
   - The Committee noted that since the last review in 2016, the measure now has separate rates for each metabolic test in addition to the combined rate of receiving both tests.
   - The measure also now combines two of the age strata.
   - The measure is based on three evidence-based clinical practice guideline recommendations from the American Academy of Child and Adolescent Psychiatry (AACAP).
     - In 2016, the Committee agreed this is an important measure to monitor side effects of prescribing antipsychotic medications to children; evidence exists to support glucose and lipid monitoring.
     - No changes in evidence with this submission over the previous submission. The Committee encouraged the developer to consider including more recent literature in the evidence presentation for the next submission.
   - HEDIS data presented for 2016-2018 reflects that for commercial and Medicaid plans, mean performance is 33-35% each year with a standard deviation of 10-13%.
   - The Committee agreed that this metabolic monitoring measure is an important part of managing patient risk and is supported by evidence from guidelines.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: H-2; M-13; L-0; I-0; 2b. Validity: H-2; M-11; L-2; I-0
Rationale:
### 2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics

#### Reliability:
- Overall reliability (mean) statistics were 0.875 for commercial plans and 0.985 for Medicaid plans.
- There was concern expressed about the average reliability statistics (i.e., 0.54, 0.64) for the lower percentiles (i.e., 10th and 25th) of the commercial population, but the overall results were deemed acceptable.

#### Validity:
- Score level results of construct validity testing indicate statistically significant moderate-to-weak correlations between the measure and other measures with preventive care components: Adolescent Well-Care Visits and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.
- There was discussion about whether the measures selected for construct validity, measures of adolescent well-care visits and well-child visits are the appropriate measures to expect strong correlations.

#### 3. Feasibility: H-4; M-11; L-0; I-0

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

**Rationale:**
- Committee noted that this measure is claims-based and considered the burden to be minimal since data is collected as part of normal processes of care.

#### 4. Use and Usability

**4a. Use:** Pass-15; No Pass-0  
**4b. Usability:** H-2; M-13; L-0; I-0

**Rationale:**
- The measure is used by commercial health plans and is in the Medicaid Child Core Set for 2020.
- Regarding usability, the Committee agreed there is opportunity for improvement, but questioned why there has not been more performance improvement over the past four years.
  - Some members felt that the measure should not be very difficult to influence.
  - Other members expressed that required public reporting may further incentivize improvement.

#### 5. Related and Competing Measures

- Committee members noted a related measure: Related Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- This was considered harmonized to the extent possible and not competing.

#### 6. Standing Committee Recommendation for Endorsement: Yes-15; No-0

The Standing Committee recommended the measure for continued endorsement.

#### 7. Public and Member Comment

#### 8. Consensus Standards Approval Committee (CSAC) Vote:

#### 9. Appeals
2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

**Submission | Specifications**

**Description:** Percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration primary indication for antipsychotics, and had documentation of psychosocial care as first-line treatment.

**Numerator Statement:** Children and adolescents 1-17 years of age who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic without a U.S. Food and Drug Administration primary indication for antipsychotic use.

**Denominator Statement:** Children and adolescents 1-17 years of age as of December 31 of the measurement year who had a new prescription of an antipsychotic medication for which they do not have a U.S. Food and Drug Administration primary indication for antipsychotics.

**Exclusions:** Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration primary indication and are thus clinically appropriate: schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder.

Patients in hospice.

**Adjustment/Stratification:** Report two age stratifications and a total rate:
- Children and adolescents 1-11 years of age as of December 31 of the measurement year.
- Children and adolescents 12-17 years of age as of December 31 of the measurement year.
- Total (the sum of the age stratifications).

No risk adjustment or risk stratification

**Level of Analysis:** Health Plan

**Setting of Care:** Outpatient Services

**Type of Measure:** Process

**Data Source:** Claims

**Measure Steward:** National Committee for Quality Assurance

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**STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020**

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

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

1a. Evidence: H-2; M-13; L-0; I-0; 1b. Performance Gap: H-3; M-12; L-0; I-0

**Rationale:**
- The Committee noted that since 2016, the measure has been updated to combine the two lower age strata but is otherwise the same.
- Based on “Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents, July 2012 (2011 guidelines).”
- It was noted there are no new studies that contradict the evidence presented, and several Committee members emphasized that this topic area needs careful attention and monitoring.
- Committee members noted that a strength of the measure is that it appropriately excludes SMI.
- The Committee noted that HEDIS data presented for 2016-2018 reflects that for commercial and Medicaid plans, mean performance is 55-60% each year with a standard deviation of 11-15%.
- The Committee agreed that there is adequate evidence to support this measure and a performance gap.

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

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

2a. Reliability: H-1; M-14; L-0; I-0; 2b. Validity: H-13; M-1; L-1; I-0

**Rationale:**
- The Committee vote reflected their consideration of score-level reliability and validity testing results as supporting the measure’s scientific acceptability.
- Overall reliability statistics were 0.797 for commercial plans and 0.980 for Medicaid plans.
### 2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

- The Committee noted that commercial plan reliability scores below 25th percentile were below 0.61.
- Construct validity was performed using four measures that reflect coordinated care across settings.

#### 3. Feasibility: H-10; M-5; L-0; I-0

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

**Rationale:**
- The Committee noted that this measure is claims-based and considered the burden to be minimal since data is collected as part of normal processes of care.

#### 4. Use and Usability

4a. Use: Pass-15; No Pass-0 4b. Usability: H-3; M-12; L-0; I-0

**Rationale:**
- Regarding use, the measure is publicly reported in various applications.
- A potential unintended consequence discussed was that there may be clinical scenarios in which a clinician would not want to hold off starting medication while trying to help patients enroll in therapy.
- The Committee emphasized the need for interventions that generate improvement on this measure soon as there has not been enough improvement over time.

#### 5. Related and Competing Measures

- No related or competing measures noted.

#### 6. Standing Committee Recommendation for Endorsement: Yes-15; No-0

The Standing Committee recommended the measure for continued endorsement.

#### 7. Public and Member Comment

#### 8. Consensus Standards Approval Committee (CSAC) Vote:

#### 9. Appeals

### 3175 Continuity of Pharmacotherapy for Opioid Use Disorder

**Description:** Percentage of adults of at least 18 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

**Numerator Statement:** Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

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

**Exclusions:** There are no denominator exclusions.

**Adjustment/Stratification:** Measure results may be stratified by:
- Age
- Gender
- Race/ethnicity
- Dual eligibility status

No risk adjustment or risk stratification.

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

**Setting of Care:** Outpatient Services

**Type of Measure:** Process
### 3175 Continuity of Pharmacotherapy for Opioid Use Disorder

**Data Source:** Claims  
**Measure Steward:** University of Southern California

**STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020**

1. **Importance to Measure and Report:** The measure meets the Importance criteria  
   (1a. Evidence, 1b. Performance Gap)  
   1a. Evidence: (N/A); 1b. Performance Gap: (N/A)

2. **Scientific Acceptability of Measure Properties:** The measure meets the Scientific Acceptability criteria  
   (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
   - 2a. Reliability: H-2; M-11; L-3; I-0; 2b. Validity: M-10; L-6; I-0

   **Rationale:**
   - The Committee noted that this measure was being considered for an ad hoc review to expand the level of analysis from population: regional and state, health plan to include clinicians at the individual and group/practice level.
   - The 2018 Measure Applications Partnership Clinician Workgroup conditionally supported the measure for MIPS pending NQF endorsement at the clinician level.
   - Abbreviated submission of new scientific testing presented to this end.
   - The measure is scheduled to be submitted for full maintenance review in 2020.
   - The Committee noted good performance for reliability.
   - Score-level, signal to noise reliability testing performed using 2013-2016 data.
     - The average reliability score for the clinician level was 0.77 (SD=0.09) for 2013-2014, 0.77 (SD=0.10) for 2014-2015, and 0.80 (SD=0.08) for 2015-2016.
     - The average reliability score at the group/practice level was 0.76 (SD=0.10) for 2013-2014, 0.76 (SD=0.10) for 2014-2015, and 0.79 (SD=0.09) for 2015-2016.
   - The measure submission noted that two-thirds of an expert panel of nine individuals agreed or strongly agreed that the measure has face validity.

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

4. **Use and Usability**
   - 4a. Use: (N/A) 4b. Usability: (N/A)

5. **Related and Competing Measures**
   - No related or competing measures noted.

6. **Standing Committee Recommendation for Endorsement:** (N/A)
   The measure passed reliability and validity at the clinician level based on the new testing provided. The endorsement of this measure is therefore recommended to be expanded to the clinician level of analysis.

7. **Public and Member Comment**

8. **Consensus Standards Approval Committee (CSAC) Vote:**

9. **Appeals**
### 3539e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

<table>
<thead>
<tr>
<th>Description</th>
<th>Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator Statement</td>
<td>Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.</td>
</tr>
<tr>
<td>Denominator Statement</td>
<td>Non-psychiatric inpatient hospitalizations for patients who are 65 and older.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter. Inpatient hospitalizations for patients who were taking antipsychotics prior to admission.</td>
</tr>
<tr>
<td>Adjustment/Stratification</td>
<td>Results include a total score and the following strata:</td>
</tr>
</tbody>
</table>

- **Stratum 1** - Patients who were admitted or transferred to the ICU during the inpatient encounter
- **Stratum 2** - Patients who were not admitted or transferred to the ICU during the inpatient encounter

These strata are identified using the QDM datatype of Encounter, Performed. ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040)

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. Stratification by risk category/subgroup

**Level of Analysis:** Facility

**Setting of Care:** Inpatient/Hospital

**Type of Measure:** Process

**Data Source:** Electronic Health Records

**Measure Steward:** Centers for Medicare & Medicare Services

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**STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020**

1. **Importance to Measure and Report:** The measure meets the Importance criteria (1a. Evidence, 1b. Performance Gap)

   1a. Evidence: H-1; M-18; L-2; I-0; 1b. Performance Gap: H-3; M-18; L-0; I-0

   **Rationale:**
   - The Committee noted that this measure was submitted in fall 2017 as NQF 3315e and reviewed by the BHSU Committee.
     - The Committee encouraged the developer to adjust the measure. Exclusions have been added.
     - Exclusions: inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette’s syndrome, bipolar disorder, Huntington’s disease during the encounter. New exclusions are inpatient hospitalizations for patients who were taking antipsychotics prior to admission.
   - The evidence for the measure includes the American Geriatrics Society 2019 guidelines and literature that indicates harm from prolonged use of antipsychotics (e.g., higher mortality rate, risk of falls, and cerebral vascular events).
   - For performance gap, the Committee agreed data show too many older patients are receiving these medications.

2. **Scientific Acceptability of Measure Properties:** The measure meets the Scientific Acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

   2a. Reliability: H-1; M-14; L-5; I-0; 2b. Validity: M-13; L-7; I-0

   **Rationale:**
3539e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

- The reliability discussion focused on whether this measure would capture appropriate on-label prescribing since on-label and off-label indications can vary widely between medications.
- Overall, the Committee supported the measure’s reliability.
  - 11 hospitals produced good reliability results (0.98) for years 2013-15.
  - 9 hospitals produced 0.95 for 2018.
- The Committee noted that the “threat of harm” element is not collected in a structured field systematically across all sites, but increased implementation of the measure would drive better data collection. The Committee voiced that, during the maintenance evaluation, they would like to assess whether “threat of harm” is being captured more consistently.

3. Feasibility: H-3; M-11; L-6; I-0
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:
- The Committee noted that some exclusions may be hard to find (threat to others or self) and may introduce burden; this was addressed during the validity discussion.

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

4a. Use: Pass-18; No Pass-2
4b. Usability: H-1; M-14; L-5; I-0

Rationale:
- Members commented that a potential unintended consequence of the measure is increased restraint use, but overall, the benefits of the measure outweigh the risks.
- The measure was designed for use in the Inpatient Hospital Quality Reporting program.

5. Related and Competing Measures
- No competing measures noted.

6. Standing Committee Recommendation for Endorsement: Yes-19; No-1
The Standing Committee recommended the measure for endorsement.

7. Public and Member Comment

8. Consensus Standards Approval Committee (CSAC) Vote:

9. Appeals

3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

Submission | Specifications

Description: The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.

Numerator Statement: Individuals in the denominator population who have not received a drug test during the measurement year.

Denominator Statement: The target population for this measure is individuals 18 years of age and older prescribed long-term opioid therapy during the measurement year. Individuals are excluded if they have had any claims indicating a cancer diagnosis or hospice care at any time during the measurement year.

Exclusions: The measure excludes individuals with: 1) a diagnosis of cancer at any time during the measurement year; or 2) hospice care at any time during the year.
3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

Adjustment/Stratification: Not applicable. No risk adjustment or risk stratification.
Level of Analysis: Health Plan
Setting of Care: Outpatient Services
Type of Measure: Process
Data Source: Claims, Enrollment Data
Measure Steward: Pharmacy Quality Alliance

STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020

1. Importance to Measure and Report: The measure meets the Importance criteria
   (1a. Evidence, 1b. Performance Gap)
   1a. Evidence: H-4; M-14; L-1; I-0; 1b. Performance Gap: H-10; M-10; L-0; I-0
   Rationale:
   • The Committee noted that the developer (PQA) provided a summary of the five evidence-based clinical practice guidelines that support the importance of drug testing for patients on long-term opioid therapy.
     o The eight guideline statements provided are generally rated moderate-to-strong for evidence and recommendation strength (only a few of the recommendation statements have low/weak support).
     o Some of the evidence is stronger for monitoring prior to initiation and for those at higher risk, but does support either annual, periodic, or random monitoring for all patients on chronic opioid therapy.
   • The Committee questioned why one test per year was selected as the threshold, and PQA responded that guidelines recommend testing either one or one-to-two times per year.
   • PQA’s TEP thought once per year was reasonable, and performance using this requirement indicated a substantial performance gap.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria
   (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
   2a. Reliability: H-1; M-16; L-3; I-0; 2b. Validity: M-15; L-3; I-1
   Rationale:
   • The Committee noted that the mean reliability for Qualified Health Plan products with at least 30 members in the denominator (n=7) was 0.85 (range: 0.59 to 0.99).
     o 52 of 62 Medicare Prescription Drug Plans (PDPs) had at least 100 beneficiaries in the denominator.
     o Mean reliability of these PDPs was 0.72. The range was not provided.
   • The Committee discussed the definition of long-term opioid therapy: 90 cumulative days’ supply of any combination of opioid medications indicated for pain.
     o The definition is supported by the literature and aligns with the duration used to define chronic pain.
     o It was noted that, in the future, the developer should explore different methodologies to account for prescriptions filled on the same day, but that it is expected that same-day fills minimally impact performance rates.

3. Feasibility: H-9; M-10; L-0; I-0
   (3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified; 3d. Data collection strategy can be implemented)
   Rationale:
   • The Committee noted that this measure is claims-based and considered the burden to be minimal since data is collected as part of normal processes of care.

4. Use and Usability
3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

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

4a. Use: Pass-19; No Pass-1
4b. Usability: H-2; M-15; L-1; I-0

Rationale:
- The Committee noted that this measure is intended for use in the Quality Rating System for Qualified Health Plans

5. Related and Competing Measures
- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: Yes-18; No-0

The Standing Committee recommended this measure for endorsement.

7. Public and Member Comment

8. Consensus Standards Approval Committee (CSAC) Vote:

9. Appeals

Measures Where Consensus Is Not Yet Reached

3492 Acute Care Use Due to Opioid Overdose

Submission | Specifications

Description: This is a population measure that indicates the rate of emergency department visits for opioid overdose events in a specified geographic region using ICD-10 diagnosis codes from claims. The outcome is defined as the incidence of overdose events per 1,000 person-years among Medicare beneficiaries greater than 18 years of age residing in the specified geographic region. The measure has been tested for use at both the county and state levels.

Numerator Statement: The numerator is comprised of incident outcome events, defined as opioid overdoses that result in emergency department use, within the population residing in a specific geography.

Denominator Statement: The denominator consists of all enrolled Medicare Fee-For-Service (FFS) beneficiaries with Parts A or B, aged 18 and older residing in a measured geography (either a county or a state) during a one-year period.

Exclusions: None

Adjustment/Stratification: None. No risk adjustment or risk stratification.

Level of Analysis: Population : Community, County or City, Population : Regional and State

Setting of Care: Emergency Department and Services, Inpatient/Hospital, Outpatient Services

Type of Measure: Outcome

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020

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

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

1a. Evidence: Pass-19; No Pass-1
1b. Performance Gap: H-2; M-9; L-6; I-2

Rationale:
- As an outcome measure, the evidence required is to demonstrate a structure, process, service, or intervention that can lead to improvement.
- Developer proffers opioid prescribing behavior modifications as a process to influence the outcome.
3492 Acute Care Use Due to Opioid Overdose

- The Committee generally felt that there are interventions that healthcare providers and systems can perform to reduce the risk of opioid overdose such as using MAT and safer prescribing practices, increasing the capacity to provide MAT, and enacting mandatory prescription drug monitoring programs.
- The discussion included the benefit of this measure over the existing indicators of ED utilization and opioid overdose.
- The Committee emphasized that overdose deaths varied four times across states and 10 times between the lowest- and highest-performing counties, exhibiting a high performance gap.

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

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

2a. Reliability: H-1; M-2; L-1; I-0; 2b. Validity: H-2; M-9; L-6; I-2

Rationale:

- This measure is deemed as complex and was evaluated by the NQF Scientific Methods Panel. SMP Subgroup Votes:
  - Reliability: H-1; M-2; L-1; I-0 (Pass)
  - Validity: H-0; M-1; L-2; I-1 (No pass)
- The Committee agreed that the score-level and data element reliability testing results indicate the measure is reliable.
- The measure submission included empirical validity testing that compares performance on the measure to performance on two other related indicators (i.e., opioid-related ED and hospital visits in an all-care population and age-adjusted rate of fatal overdose) in 25 states.
  - Results showed the measure was highly correlated with the other measures.
  - It was discussed that social risk factors are not distributed equally across states or counties.
  - During the post-comment meeting, the Committee wanted to discuss whether overdoses are coded appropriately.
- The Committee did not reach consensus on validity, a must-pass criterion.

3. Feasibility: H-2; M-11; L-2; I-0

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

Rationale:

- The Committee noted that this measure is claims-based and considered the burden to be minimal since data is collected as part of normal processes of care.

4. Use and Usability

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

4a. Use: Pass-13; No Pass-3 4b. Usability: H-2; M-10; L-4; I-0

Rationale:

- The Committee noted that this is a new measure and did not express any concerns related to usability and use.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement:

The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on validity—a must-pass criterion.

7. Public and Member Comment

8. Consensus Standards Approval Committee (CSAC) Vote:

9. Appeals
**3538 All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care**

**Submission | Specifications**

**Description:** The measure focuses on emergency department (ED) utilization for four populations of Medicaid beneficiaries who may benefit from integrated physical and behavioral health care. The rates in this measure are intended to be reported at the state level. This is an inverse measure; lower scores indicate better quality of care.

The measure is defined as the all-cause ED utilization rate for Medicaid beneficiaries age 18 and older who meet the eligibility criteria for any of the four denominator groups:

1. Beneficiaries with co-occurring physical health and mental health conditions (PH+MH)
2. Beneficiaries with a co-occurring physical health condition and a substance use disorder (PH+SUD)
3. Beneficiaries with a co-occurring mental health condition and a SUD (MH+SUD)
4. Beneficiaries with serious mental illness (SMI)

The measure is calculated over the period of one calendar year as the number of ED visits that do not result in an inpatient admission or observation stay per 1,000 member-months. It is reported as four separate rates, one for each denominator group.

Each of the four denominator groups includes only beneficiaries who were not dually eligible, were enrolled in Medicaid for at least 10 months of the measurement year, and had a diagnosis within the measurement year or year prior (depending upon the condition) that placed them into one or more of the denominator groups.

**Numerator Statement:** The numerator is the number of ED visits during the measurement year that did not result in an inpatient or observation stay among non-dual eligible Medicaid beneficiaries age 18 and older with at least 10 months of enrollment who met the eligibility criteria for any of the four denominator groups during the look-back year.

**Denominator Statement:** The number of Medicaid-enrolled months (“beneficiary-months”) among Medicaid beneficiaries who meet eligibility criteria for any of the four denominator groups:

1. Beneficiaries with co-occurring physical health and mental health conditions (PH+MH)
2. Beneficiaries with a co-occurring physical health condition and a SUD (PH+SUD)
3. Beneficiaries with a co-occurring mental health condition and a SUD (MH+SUD)
4. Beneficiaries with serious mental illness (SMI)

**Exclusions:** None.

**Adjustment/Stratification:** Statistical risk model.

**Level of Analysis:** Population: Regional and State

**Setting of Care:** Emergency Department and Services

**Type of Measure:** Outcome

**Data Source:** Claims

**Measure Steward:** Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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**STANDING COMMITTEE MEETING 01/29/2020, 01/31/2020, 02/05/2020**

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

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

1a. Evidence: **Pass-10; No Pass-9;** 1b. Performance Gap: **H-1; M-14; L-3; I-2**

**Rationale:**
- The Committee noted that this new measure is intended for use in state Medicaid to improve quality of care for beneficiaries with physical and mental health integration needs.
- The denominator includes four strata: beneficiaries with co-occurring physical health and mental health conditions, beneficiaries with co-occurring physical health conditions and an SUD, beneficiaries with co-occurring mental health conditions and a SUD, and beneficiaries with SMI.
The developer proffers integrated care as a process to influence the outcome, and evidence indicates state-level integrated care pilot programs have shown promise in reducing ED use for those with the need for integrated care.

There was considerable discussion about how the outcome represents true quality of care.

The Committee agreed that performance data can lead to multiple downstream outcomes and drive change, but they had some concern that there are factors other than adequate outpatient care and appropriate care coordination, including but not limited to, SDOH that play a significant role in why individuals frequent the ED.

It was also noted that adequate use is determined by whether an ED visit results in an observation or inpatient psychiatric stay, but there are shortages of psychiatric inpatient beds available in some places.

The Committee discussed that data from 17 states showed high ED use and opportunity for improvement.

In the future, the Committee is interested in reviewing normative rates of ED use or rates by a single diagnosis to better understand the appropriate measure benchmark.

The Committee did not achieve consensus on evidence—a must-pass criterion.

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

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

2a. Reliability: Yes-18; No-2; 2b. Validity: Yes-16; No-5

Rationale:

- This measure is deemed as complex and was evaluated by the NQF Scientific Methods Panel. SMP subgroup votes:
  - Reliability: H-5; M-1; L-0; I-0
  - Validity: H-5; M-1; L-0; I-0
- Across all states, average SNR ranged from 0.96 and 0.98 for the four denominator groups. The SNR ranged from 0.89 to 0.99 for beneficiaries in the PH+MH group, 0.80 to 0.99 for beneficiaries in the PH+SUD group, 0.83 to 0.99 for beneficiaries in the PH+SUD denominator group, and 0.77 to 0.99 in the SMI denominator group.
- For validity, the Committee noted that test results were mixed, with some modest and low correlations where one would expect to see a correlation.
- Some members expressed that social factors could unfairly impact measure rates, but others noted that the measure should not be adjusted in order to fully understand the factors driving results at the state level.

3. Feasibility: H-6; M-15; L-0; I-0

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

Rationale:

- The Committee agreed that the measure is feasible without additional discussion.

4. Use and Usability

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

4a. Use: Pass-17; No Pass-4 4b. Usability: H-2; M-12; L-6; I-1

Rationale:

- The Committee noted that the measure is not yet in use, but a plan for potential use was presented.
- Additional details about how performance is tracked, compared, and used by states to inform integrated care will be useful in the future.

5. Related and Competing Measures
<table>
<thead>
<tr>
<th>3538 All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No competing measures noted.</td>
</tr>
</tbody>
</table>

6. **Standing Committee Recommendation for Endorsement:**
The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on evidence—a must-pass criterion.

7. **Public and Member Comment**

8. **Consensus Standards Approval Committee (CSAC) Vote:**

9. **Appeals**
## Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Title</th>
<th>Federal Programs</th>
</tr>
</thead>
</table>
| 0004  | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Merit-based Incentive Payment System (MIPS) (Implemented 2018)  
Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2015)  
Medicaid (Implemented 2013) |
| 0004e | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eMeasure) | Merit-based Incentive Payment System (MIPS) (Implemented 2018) |
| 0027  | Medical Assistance With Smoking and Tobacco Use Cessation             | Medicaid (Implemented 2018)  
Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016) |
| 0028  | Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention | Merit-based Incentive Payment System (MIPS) (Implemented 2018)  
Medicare Shared Savings Program (MSSP) (Implemented 2012) |
| 0028e | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure) | Merit-based Incentive Payment System (MIPS) (Implemented 2018)  
Million Hearts (Implemented 2018)  
Medicaid Promoting Interoperability Program (Implemented 2019) |
| 0104  | Adult Major Depressive Disorder: Suicide Risk Assessment             | Merit-based Incentive Payment System (MIPS) (Implemented 2016) |
| 0104e | Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure) | Merit-based Incentive Payment System (MIPS) (Implemented 2018)  
Medicaid Promoting Interoperability Program (Implemented 2019) |
| 0105  | Antidepressant Medication Management (AMM)                          | Merit-based Incentive Payment System (MIPS) (Finalized 2016)  
Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016)  
Medicaid (Implemented 2013) |

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*Per CMS Measures Inventory Tool as of February 28, 2020*

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NQF REVIEW DRAFT—Comments due by May 14, 2020 by 6:00 PM ET.
<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Measure Description</th>
<th>Measure Details</th>
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<tr>
<td>0105e</td>
<td>Antidepressant Medication Management (AMM) (eMeasure)</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)</td>
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<tr>
<td>0108e</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication (ADD) (eMeasure)</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)</td>
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<td>0418</td>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan</td>
<td>Medicaid (Implemented 2018)</td>
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<td>0418e</td>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eMeasure)</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)</td>
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<tr>
<td>0560</td>
<td>HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification</td>
<td>Hospital Compare (Implemented 2013) Inpatient Psychiatric Quality Reporting (Implemented 2013)</td>
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<tr>
<td>0640</td>
<td>HBIPS-2 Hours of physical restraint use</td>
<td>Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)</td>
</tr>
<tr>
<td>0641</td>
<td>HBIPS-3 Hours of seclusion use</td>
<td>Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)</td>
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<td>Code</td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>0710e</td>
<td>Depression Remission at Twelve Months (eMeasure)</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018)</td>
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<td></td>
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<td>Medicaid Promoting Interoperability Program (Implemented 2019)</td>
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<tr>
<td>0711</td>
<td>Depression Remission at Six Months</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Implemented 2018/Scheduled Removal 2021))</td>
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<tr>
<td>0712e</td>
<td>Depression Utilization of the PHQ-9 Tool (eMeasure)</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018)</td>
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<td></td>
<td>Medicaid Promoting Interoperability Program (Implemented 2019)</td>
</tr>
<tr>
<td>1365</td>
<td>Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018)</td>
</tr>
<tr>
<td>1365e</td>
<td>Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018)</td>
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<td>Medicaid Promoting Interoperability Program (Implemented 2019)</td>
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<td>1879</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018)</td>
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<td>Medicaid (Implemented 2013)</td>
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<tr>
<td>1932</td>
<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</td>
<td>Medicaid (Implemented 2018)</td>
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<tr>
<td>2152</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>Merit-based Incentive Payment System (MIPS) (Implemented 2018)</td>
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<tr>
<td>2605</td>
<td>Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence</td>
<td>Medicaid (Implemented 2018)</td>
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<tr>
<td>2607</td>
<td>Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</td>
<td>Medicaid (Implemented 2017)</td>
</tr>
<tr>
<td>3175</td>
<td>Continuity of Pharmacotherapy for Opioid Use Disorder</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized 2018/Scheduled for implementation 2020)</td>
</tr>
</tbody>
</table>
Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

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Kraig Knudsen, PhD

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Project Analyst

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Appendix D: Measure Specifications

2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics

STEWARD
National Committee for Quality Assurance

DESCRIPTION
The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

TYPE
Process

DATA SOURCE
Claims This measure is part of the Healthcare Effectiveness Data and Information Set (HEDIS). This measure pulls from administrative claims collected in the course of providing care to health plan members. NCQA collects the HEDIS data for this measure directly from health plans via NCQA’s online data submission system.

LEVEL
Health Plan

SETTING
Emergency Department and Services, Outpatient Services

NUMERATOR STATEMENT
Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.

NUMERATOR DETAILS
Three numerators are reported using administrative data:
1. Children and adolescents 1-17 years of age on antipsychotics who received blood glucose testing during the measurement year.
2. Children and adolescents 1-17 years of age on antipsychotics who received cholesterol testing during the measurement year.
3. Children and adolescents on antipsychotics who received blood glucose and cholesterol testing during the measurement year.

Blood Glucose Testing: one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol Testing: one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.
Blood Glucose and Cholesterol Testing: both of the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

See attachment for all value sets referenced above.

DENOMINATOR STATEMENT

Children and adolescents 1-17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions).

DENOMINATOR DETAILS

Children and adolescents age 1-17 years as of December 31 of the measurement year who had at least two antipsychotic medication dispensing events (Table APM-A) of the same or different medications, on different dates of service during the measurement year, with no more than one gap in enrollment of up to 45 days during the measurement year.

TABLE APM-A: ANTIPSYCHOTIC MEDICATIONS

<table>
<thead>
<tr>
<th>DESCRIPTION / PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antipsychotic agents / Aripiprazole; Asenapine; Brexpiprazole; Cariprazine; Clozapine; Haloperidol; Iloperidone; Loxapine; Lurisdione; Molindone; Olanzapine; Paliperidone; Pimozide; Quetiapine; Quetiapine fumarate, Risperidone, Ziprasidone</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics / Chlorpromazine; Fluphenazine; Perphenazine; Thoridazine; Trifluoperazine</td>
</tr>
<tr>
<td>Thiothixene / Thiothixene</td>
</tr>
<tr>
<td>Long-acting injections / Aripiprazole; Fluphenazine decanoate; Haloperidol decanoate; Olanzapine; Paliperidone palmitate; Risperidone</td>
</tr>
<tr>
<td>Psychotherapeutics combinations / Fluoxetine-olanzapine; Perphenazine-amitriptyline</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics / Prochlorperazine</td>
</tr>
</tbody>
</table>

EXCLUSIONS

Patients in hospice.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Encounter Value Set or Hospice Intervention Value Set).

See corresponding Excel file for value sets referenced above.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Report two age stratifications and a total rate:

NATIONAL QUALITY FORUM

NQF REVIEW DRAFT—Comments due by May 14, 2020 by 6:00 PM ET.
• Children and adolescents 1-11 years of age as of December 31 of the measurement year.
• Children and adolescents 12-17 years of age as of December 31 of the measurement year.
• Total (the sum of the age stratifications).

TYPE SCORE
Rate/proportion better quality = higher score

ALGORITHM
STEP 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.
- AGES: Children and adolescents 1-17 years of age as of December 31 of the measurement year.
- EVENT/DIAGNOSIS: Identify patients who had at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year. SEE S.7 for the list of antipsychotic medications.

STEP 2: Determine the numerator by identifying the number of patients in the eligible population who received blood glucose testing, cholesterol testing, or blood glucose testing and cholesterol testing.

STEP 3: Calculate the rate by dividing the numerator by the denominator. 123834

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2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

STEWARD
National Committee for Quality Assurance

DESCRIPTION
Percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration primary indication for antipsychotics, and had documentation of psychosocial care as first-line treatment.

TYPE
Process

DATA SOURCE
Claims This measure is part of the Healthcare Effectiveness Data and Information Set (HEDIS). This measure pulls from administrative claims collected in the course of providing care to health plan members. NCQA collects the HEDIS data for this measure directly from health plans via NCQA’s online data submission system.

LEVEL
Health Plan

SETTING
Outpatient Services

NUMERATOR STATEMENT
Children and adolescents 1-17 years of age who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic without a U.S. Food and Drug Administration primary indication for antipsychotic use.

NUMERATOR DETAILS
The numerator is reported using administrative data and includes children and adolescents who had documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period spanning 90 days prior to the IPSD through 30 days after the IPSD during the measurement year (January 1 – December 1).

The IPSD is earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions.

See attachment for all value sets reference above (S.2b).

DENOMINATOR STATEMENT
Children and adolescents 1-17 years of age as of December 31 of the measurement year who had a new prescription of an antipsychotic medication for which they do not have a U.S. Food and Drug Administration primary indication for antipsychotics.
DENOMINATOR DETAILS

Children and adolescents age 1-17 year as of December 31 of the measurement year who had a new prescription for an antipsychotic medication (Table APP-A) during the Intake Period. Details to identify the eligible population are below.

STEP 1: Identify all patients in the specified age range who were dispensed an antipsychotic medication (Table APP-A) during the Intake Period.

STEP 2: Test for Negative Medication History. For each member identified in Step 1, test each antipsychotic prescription for a Negative Medication History. The Index Period Start Date (IPSD) is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History.

STEP 3: Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

TABLE APP-A: ANTIPSYCHOTIC MEDICATIONS

<table>
<thead>
<tr>
<th>DESCRIPTION / PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antipsychotic agents / Aripiprazole; Asenapine;</td>
</tr>
<tr>
<td>Brexpiprazole; Cariprazine; Clozapine; Haloperidol; Iloperidone;</td>
</tr>
<tr>
<td>Loxapine; Lurisadone; Molindone; Olanzapine; Paliperidone;</td>
</tr>
<tr>
<td>Pimozide; Quetiapine; Quetiapine fumarate; Risperidone; Ziprasidone</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics / Chlorpromazine; Fluphenazine;</td>
</tr>
<tr>
<td>Perphenazine; Thoridazine; Trifluoperazine</td>
</tr>
<tr>
<td>Thiothixene / Thiothixene</td>
</tr>
<tr>
<td>Long-acting injections / Aripiprazole; Fluphenazine decanoate;</td>
</tr>
<tr>
<td>Haloperidol decanoate; Olanzapine; Paliperidone palmitate;</td>
</tr>
<tr>
<td>Risperidone</td>
</tr>
<tr>
<td>Psychotherapeutic combinations / Fluoxetine-olanzapine;</td>
</tr>
<tr>
<td>Perphenazine-amitriptyline</td>
</tr>
</tbody>
</table>

EXCLUSIONS

Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration primary indication and are thus clinically appropriate: schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder.

Patients in hospice.

EXCLUSION DETAILS

Exclude children and adolescents for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria:

- At least one acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations meet criteria:
  -- BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set).
  -- Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with (Schizophrenia Value Set; Bipolar Value Set; Other Psychotic and Developmental Disorders Value Set).
- At least two visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations with (Schizophrenia Value Set;
Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set) meet criteria:
-- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).
-- An outpatient visit (BH Outpatient Value Set).
-- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)
-- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).
-- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
-- An observation visit (Observation Value Set).
-- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set).

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Encounter Value Set or Hospice Intervention Value Set).

See corresponding Excel file for value sets referenced above.

RISK ADJUSTMENT
No risk adjustment or risk stratification

STRATIFICATION
Report two age stratifications and a total rate:
• Children and adolescents 1-11 years of age as of December 31 of the measurement year.
• Children and adolescents 12-17 years of age as of December 31 of the measurement year.
• Total (the sum of the age stratifications).

TYPE SCORE
Rate/proportion better quality = higher score

ALGORITHM
STEP 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.
- AGES: Children and adolescents 1-17 years as of December 31 of the measurement year.
- EVENT/DIAGNOSIS: Identify the number of children and adolescents who were newly dispensed an antipsychotic medication during the intake period. SEE S.7 for the list of antipsychotic medications.

STEP 2: Exclude patients who meet the exclusion criteria. SEE S.8 and S.9 for denominator exclusion criteria and details.

STEP 3: Determine the numerator by identifying the number of children and adolescents in the eligible population who had documentation of psychosocial care in the 121-day period spanning 90 days prior through 30 days after the new prescription of an antipsychotic.

STEP 4: Calculate the rate by dividing the numerator (Step 3) by the denominator (after exclusions) (Step 2). 123834
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3175 Continuity of Pharmacotherapy for Opioid Use Disorder

STEWARD
University of Southern California

DESCRIPTION
Percentage of adults of at least 18 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

TYPE
Process

DATA SOURCE
Claims For measure calculation, the following files from the Truven MarketScan® Commercial Database and the Medicare 100% Research Identifiable Files (RIF) were used:

- Enrollment data
- Drug claims/prescription drug events
- Medical claims

We used data from these files for calendar years 2010-2016. The MarketScan database has long been a commonly used data source to study patterns of commercially insured patients. The Medicare RIF files contain all claims for beneficiaries in traditional Medicare. Both databases contain fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure’s eligibility criteria.

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

SETTING
Outpatient Services

NUMERATOR STATEMENT
Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

NUMERATOR DETAILS
The measure numerator is calculated based on claims data for rolling two-year periods. The measure numerator is defined as individuals in the denominator with at least 180 days of “continuous pharmacotherapy” with an OUD medication.

Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days’ supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days’ supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days’ supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the
individual during the measurement period. If two or more prescription claims occur on the same
day or overlap, the surplus based on the days’ supplies accumulates over all prescriptions.
However, if another claim is submitted after a claim for an injectable/implantable OUD
medication or an oral OUD medication that is dispensed in an office or treatment center, the
surplus from the day’s supply for the injectable/implantable or office-dispensed medication is
not retained.

An individual is considered to have continuous pharmacotherapy with OUD medication if there
is no treatment gap of more than seven days. A gap is defined as a period during which the
individual does not have oral OUD medication available based on the days’ supply, or is more
than 7 days overdue for having an injection of an extended-release OUD medication.

OUD medications were identified using National Drug Codes (NDCs) for the following:
- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:
- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended-release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable
medications and office-dispensed oral medications (methadone and buprenorphine/naloxone)
are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file
called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the
NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as
OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through
a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

Justification of Measure Definition: We define treatment continuity as (1) receiving at least 180
days of treatment and (2) no gaps in medication use of more than 7 days.

Our definition of minimum duration is based on the fact that the FDA registration trials for OUD
drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb,
undated), and we have no evidence for effectiveness of shorter durations. In addition, several
recommendations support a minimum six-month treatment period as the risk of relapse is the
highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb,
undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes
compared to shorter treatments and the best outcomes have been observed among patients in
long-term methadone maintenance programs (“Effective medical treatment of opiate
addiction”, 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles
et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is
associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We
did not specify a maximum duration of treatment, as no upper limit for duration of treatment
has been empirically established (US DHHS, 2015).

We opted for using a treatment gap of more than seven days in our definition, given that the
measure includes three active ingredients with different pharmacological profiles. There is
substantial evidence for an elevated mortality risk immediately after treatment cessation
(Cornish et al., 2010; Cousins et al., 2016; Davoli et al, 2007; Degenhardt et al., 2009; Gibson &
Degenhardt, 2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends reevaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; “Drug Misuse and Dependence—Guidelines on Clinical Management”, 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation.

Citations


DENOMINATOR STATEMENT

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

DENOMINATOR DETAILS

The measure denominator is calculated for rolling two-year periods. The denominator includes individuals of at least 18 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period.

The diagnosis codes used to identify individuals with OUD included:

- ICD-9: 304.0x, 305.5x
- ICD-10: F11.xxx

These codes and descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)
The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.

EXCLUSIONS
There are no denominator exclusions.

EXCLUSION DETAILS
There are no denominator exclusions.

RISK ADJUSTMENT
No risk adjustment or risk stratification

STRATIFICATION
Measure results may be stratified by:
- Age
- Gender
- Race/ethnicity
- Dual eligibility status

TYPE SCORE
Rate/proportion better quality = higher score

ALGORITHM
The measure score is calculated for rolling two-year periods.
DENOMINATOR: Individuals of at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication
CREATE DENOMINATOR:
1. For each two-year period, identify individuals who are at least 18 years of age for the duration of the first year during which they appear in the period.
2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists”, which is attached to this form under Item S.2b.
3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-year period with a date at least 180 days before the end of the final calendar year of the measurement period:
   - Buprenorphine
   - Naltrexone (oral)
• Buprenorphine and Naloxone

Or a HCPCS code for any of the following OUD medications:
• Buprenorphine or Buprenorphine/naloxone, oral
• Buprenorphine (extended release injectable or implant)
• Methadone administration
• Naltrexone (extended-release injectable)

Claims for oral medications with negative, missing, or zero days’ supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists,” which is attached to this form under Item S.2b.

4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator.

NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

CREATE NUMERATOR:

For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method:

1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of:
   • The date on which the individual exhausts their days’ supply, including any pre-existing surplus, following their final claim (assuming daily use).
   • The individual’s death date.
   • December 31st of the second year in the two-year period.

2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days’ supply.

2a. Sort OUD medication claims by individual’s ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days’ supply from other prior or same-day fills.

2b. Naltrexone and buprenorphine injections contribute 30 days’ supply and a buprenorphine implant 180 days unless another claim is found sooner, in which case the injection or implant covers only the days up to the next claim.

2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575).

2d. Claims for injections/implants and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted.
2e. For claims with a days’ supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days’ supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing.

4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator.

CALCULATE MEASURE SCORE:

1. Calculate the measure score by dividing the numerator by the denominator.

2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator.

3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator.

4. Calculate the measure score for each clinician and clinician-group/practice level. Attribute individuals to clinicians and clinician-groups/practices based on the plurality of treatment days covered. Clinicians are identified based on their National Provider Identifier and clinician-groups/practices based on their Tax Identification Number. The measure score is reported for clinicians and clinician-group/practices with at least 25 denominator-eligible patients attributed to them. Details of the attribution method and its empirical justification are described in the attached Attribution Analysis document 123001|148777|141015

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3492 Acute Care Use Due to Opioid Overdose

STEWARD
Centers for Medicare & Medicaid Services (CMS)

DESCRIPTION
This is a population measure that indicates the rate of emergency department visits for opioid overdose events in a specified geographic region using ICD-10 diagnosis codes from claims. The outcome is defined as the incidence of overdose events per 1,000 person-years among Medicare beneficiaries greater than 18 years of age residing in the specified geographic region. The measure has been tested for use at both the county and state levels.

TYPE
Outcome

DATA SOURCE
Claims Data for measure development and testing were collected from the Medicare Fee-For-Service (FFS) claims data. We used a 100% sample of Medicare beneficiaries for 25 states and used both inpatient and outpatient claims to identify emergency department visits. We used data from 2017 for measure development and validation.

Medicare claims: This data source contains claims data for FFS inpatient and outpatient services including Medicare inpatient hospital care, outpatient hospital services (which includes emergency services) and physician services (carrier claims).

Medicare Enrollment Database (EDB): This database contains Medicare beneficiary demographic, benefit/coverage, and vital status information. This data source was used to obtain information on Medicare enrollment status during the measurement period.

LEVEL
Population : Community, County or City, Population : Regional and State

SETTING
Emergency Department and Services, Inpatient/Hospital, Outpatient Services

NUMERATOR STATEMENT
The numerator is comprised of incident outcome events, defined as opioid overdoses that result in emergency department use, within the population residing in a specific geography.

NUMERATOR DETAILS
The numerator is comprised of outcome events, i.e., emergency department (ED) visits for opioid overdose. This numerator includes all overdose events that result in treatment in the emergency department in the measured population within a one-year measurement period. The measured population is defined below in Section 5.6 and 5.7.

To capture overdose events, the measure first identifies all ED visits for the measured population using a validated algorithm (Venkatesh, 2017). Details of this algorithm are included in the measure Data Dictionary. From among these ED visits, the measure then identifies visits for opioid overdose using a set of ICD-10 diagnostic codes. Opioid overdose is defined by the presence of a diagnostic code indicating opioid poisoning such as T400X4A (Poisoning by opium,
undetermined, initial encounter). This code can appear as either a principal discharge diagnosis or a secondary diagnosis. The measure outcome definition excludes ICD-10 codes indicating intentional overdose or assault. Only diagnostic codes indicating an initial encounter are included. See the Data Dictionary for the full set of codes comprising the outcome definition.

Opioid overdoses resulting in an ED visit are included regardless of final disposition (e.g., admission, discharge etc.) or vital status (i.e., alive or deceased) at discharge. Repeat events for individual patients are also included, as the goal of the measure is to capture all unintentional opioid overdoses in the measured population. Indeed, an overdose is a risk factor for subsequent overdose, and has been proposed as an important opportunity for intervention (Larochelle, 2018). Thus, including repeat events is important for measuring opioid overdose as a population health measure. Outcome events are attributed to a geography based on a person’s residence, not based on the emergency department in which an individual seeks care. Reference


DENOMINATOR STATEMENT

The denominator consists of all enrolled Medicare Fee-For-Service (FFS) beneficiaries with Parts A or B, aged 18 and older residing in a measured geography (either a county or a state) during a one-year period.

DENOMINATOR DETAILS

The denominator includes all Medicare beneficiaries enrolled in Medicare Part A or B who are at least 18 years of age residing in the measured geography. The denominator reflects the size of the population in which overdose events occur, measured in person-years. Person-years is calculated by summing the fraction of a year each eligible beneficiary is enrolled in Medicare over the entire measured population. For example, one person enrolled for a year would contribute one person-year to the denominator. One person enrolled for 6 months would contribute 0.5 person-years. These enrollment periods are summed over the entire eligible population to calculate the total person-years for. Periods during which beneficiaries are not enrolled are considered periods during which the outcome cannot be measured and therefore are not included in the denominator.

The measure is designed to be used as a population health measure and has been tested at two different geographic levels, the county and the state. Eligible beneficiaries are assigned to geographies based on place of residence. Thus, individuals contribute to the denominator and the numerator based on residence rather than where the event took place.

Identifying emergency department visits requires information from both inpatient and outpatient claims which are covered by Medicare Parts A and B respectively. In order to be maximally inclusive, the measure includes all beneficiaries with either Part A or B, rather than requiring that beneficiaries have Parts A and B. Limiting the measure to beneficiaries who have Parts A and B would exclude individuals with observable outcome events. For example, beneficiaries with Part A would have observable outcome events if they are admitted to the hospital for an opioid overdose while those with Part B would have an observable outcome.
event if they were seen only in the emergency department. Although this approach may miss some outcome events for beneficiaries with only Parts A or B, it allows the measure to be maximally inclusive of both the measured population and potential outcome events.

EXCLUSIONS
None

EXCLUSION DETAILS
None

RISK ADJUSTMENT
No risk adjustment or risk stratification

STRATIFICATION
None

TYPE SCORE
Rate/proportion better quality = lower score

ALGORITHM
This measure estimates the rate of emergency department visits for opioid overdose events. Events are measured per 1,000 person-years among Medicare beneficiaries 18 years of age or older residing in the geography being measured. The calculation is detailed below:
1. Identify target population: (Medicare Part A or B enrollment, age 18 years or older residing in a measured geography in the measured timeframe)
2. Calculate enrollment period for each eligible beneficiary
3. Calculate total person-years for the geography of interest by summing person-years among included beneficiaries
4. Calculate numerator (overdose events resulting in an emergency department visit according to the measure definition)
5. Calculate ratio of numerator to denominator * 1,000

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3538 All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care

STEWARD
Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

DESCRIPTION
The measure focuses on emergency department (ED) utilization for four populations of Medicaid beneficiaries who may benefit from integrated physical and behavioral health care. The rates in this measure are intended to be reported at the state level. This is an inverse measure; lower scores indicate better quality of care.

The measure is defined as the all-cause ED utilization rate for Medicaid beneficiaries age 18 and older who meet the eligibility criteria for any of the four denominator groups:
1. Beneficiaries with co-occurring physical health and mental health conditions (PH+MH)
2. Beneficiaries with a co-occurring physical health condition and a substance use disorder (PH+SUD)
3. Beneficiaries with a co-occurring mental health condition and a SUD (MH+SUD)
4. Beneficiaries with serious mental illness (SMI)

The measure is calculated over the period of one calendar year as the number of ED visits that do not result in an inpatient admission or observation stay per 1,000 member-months. It is reported as four separate rates, one for each denominator group.

Each of the four denominator groups includes only beneficiaries who were not dually eligible, were enrolled in Medicaid for at least 10 months of the measurement year, and had a diagnosis within the measurement year or year prior (depending upon the condition) that placed them into one or more of the denominator groups.

TYPE
Outcome

DATA SOURCE
Claims This measure is calculated by using administrative Medicaid claims data.

LEVEL
Population : Regional and State

SETTING
Emergency Department and Services

NUMERATOR STATEMENT
The numerator is the number of ED visits during the measurement year that did not result in an inpatient or observation stay among non-dual eligible Medicaid beneficiaries age 18 and older with at least 10 months of enrollment who met the eligibility criteria for any of the four denominator groups during the look-back year.
NUMERATOR DETAILS

ED visits are defined by using the codes in the ED Visit Value Set file. Specifically, ED visits are identified by using any of the following claim type, revenue code, and procedure code combinations in the HEDIS value sets:

1. Outpatient claims with revenue codes in the ED Value Set
2. Professional claims with CPT codes in the ED Value Set
3. Professional claims with Place of Service (POS) code in the ED POS Value Set and CPT codes in the ED Procedure Code Value Set

Inpatient admissions are identified by using institutional claims for inpatient hospital services. Observation stays are identified by using codes from two sources:

1. Procedure codes in the HEDIS Observation Value Set in the ED Visit Value Set file.
2. Revenue and procedure codes created by the Centers for Medicare & Medicaid Services (CMS) to identify observation stays. We identify observation stays of any length.

ED visits are included only if they do not result in an inpatient admission or observation stay (of any length). If an ED visit’s dates of service overlap with or are within one calendar day of an inpatient admission date, it is not included in the numerator count. Claims are de-duplicated to ensure no more than one ED visit per beneficiary per day. ED visits are only counted as observed ED visits if they occur during months in which a beneficiary is enrolled in Medicaid FFS or managed care during the measurement year.

DENOMINATOR STATEMENT

The number of Medicaid-enrolled months (“beneficiary-months”) among Medicaid beneficiaries who meet eligibility criteria for any of the four denominator groups:

1. Beneficiaries with co-occurring physical health and mental health conditions (PH+MH)
2. Beneficiaries with a co-occurring physical health condition and a SUD (PH+SUD)
3. Beneficiaries with a co-occurring mental health condition and a SUD (MH+SUD)
4. Beneficiaries with serious mental illness (SMI)

DENOMINATOR DETAILS

The denominator is calculated as the number of Medicaid-enrolled months during the measurement year among non-dual eligible Medicaid beneficiaries age 18 and older who meet the eligibility criteria for any of the four denominator groups during the measurement year. Medicaid beneficiaries must have at least 10 months of Medicaid eligibility during the measurement year to ensure sufficient utilization data.

The measurement period is 12 months. An additional 12 months of look-back data is needed to identify beneficiaries’ eligibility for the denominator groups during the measurement year, for a total of 24 months of data.

Eligibility criteria for each denominator group is as follows:

1. PH+MH: Medicaid beneficiaries with (a) at least one physical health condition, as defined in the physical health value set, and (b) at least one mental health condition, as defined in the mental health value set (see attached CCW Value Set file).

2. PH+SUD: Medicaid beneficiaries with (a) at least one physical health condition, as defined in the physical health value set, and (b) at least one SUD, as defined in the substance use value set (see attached CCW Value Set file).
3. MH+SUD: Medicaid beneficiaries with (a) at least one mental health condition, as defined in the mental health value set, and (b) at least one SUD, as defined in the substance use value set (see attached CCW Value Set file).

4. SMI: Medicaid beneficiaries who meet at least one of the following criteria during the measurement year or the year prior:

I. At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression by using any of the following code combinations from the HEDIS value sets (see attached SMI Value Set file):
   • BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses:
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
     o Major Depression Value Set
   • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses:
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
     o Major Depression Value Set

II. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED, or non-acute inpatient setting on different dates of service with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations from the HEDIS value sets meet the criteria:
   • BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses (see attached SMI Value Set file):
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
   • BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses (see attached SMI Value Set file):
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
   • ED Value Set with one of the following diagnoses (see attached ED Visits Value Set and SMI Value Set files):
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
   • BH ED Value Set with BH ED POS Value Set and one of the following diagnoses (see attached SMI Value Set file):
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
   • BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses (see attached SMI Value Set file):
     o Schizophrenia Value Set
     o Bipolar Disorder Value Set
• BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses (see attached SMI Value Set file):
  o Schizophrenia Value Set
  o Bipolar Disorder Value Set

See the CCW Value Set, ED Visits Value Set, and SMI Value Set Excel files for the full value sets. The physical health conditions, mental health conditions, and substance use disorder value sets are defined in the CCW Value Set file by using Chronic Condition Warehouse algorithms. Serious mental illness is defined by using HEDIS value sets in the SMI Value Set file.

EXCLUSIONS
None.

EXCLUSION DETAILS
None.

RISK ADJUSTMENT
Statistical risk model

STRATIFICATION
None.

TYPE SCORE
Rate/proportion better quality = lower score

ALGORITHM

The following subsections provide measure logic for states to calculate: (1) the observed (i.e., unadjusted) measure rate and (2) the risk-adjusted measure rate for each denominator group. States can use the unadjusted measure rate for internal quality improvement purposes (see steps 1-3). For all other purposes, including making any comparisons among the measure’s four denominator groups, states should use the risk-adjusted measure rate (see steps 4-6).

1. OBSERVED RATE DENOMINATOR

Calculate the number of beneficiary months among adult Medicaid beneficiaries who meet eligibility criteria for any of the measure’s four denominator groups as defined above.

Step 1A: Identify Medicaid beneficiaries who (1) were age 18 and older as of January 1 of the measurement year, (2) were not dually eligible for Medicaid and Medicare between January 1 and December 31 of the measurement year, and (3) had at least 10 months of Medicaid-only enrollment during the measurement year.

Step 1B: From this group, identify beneficiaries who belong to each of the four denominator groups by using the relevant value sets for each denominator group (see the CCW Value Set, ED Visit Value Set, and SMI Value Set Excel files). Beneficiaries may belong to more than one of the denominator groups, which are not mutually exclusive. All subsequent steps should be undertaken for the beneficiaries identified in this step.

Step 1C: Among the beneficiary population identified in Step 1B, sum the number of beneficiary months on or between January 1 and December 31 of the measurement year for the members of each denominator group, respectively. A beneficiary month is one in which the beneficiary is enrolled in Medicaid FFS or managed care. The resulting number of beneficiary months is the denominator of the observed measure rate.
2. OBSERVED RATE NUMERATOR
Calculate the number of all-cause ED visits among adult, non-dual eligible Medicaid beneficiaries with at least 10 months of enrollment who meet eligibility criteria for any of the four denominator groups during the measurement year.

Step 2A: Among the population identified in Step 1B, identify the total number of ED visits (see the ED Visit Value Set Excel file) in the measurement year separately for each of the four denominator groups.

Step 2B: Identify and exclude ED visits that result in an inpatient admission or observation stay (see the ED Visit Value Set Excel file). If an ED visit’s dates of service overlap with or are within one calendar day of an inpatient (or observation) admission date, exclude it from the numerator count.

Step 2C: De-duplicate ED visits to ensure that there is no more than one ED visit per beneficiary per day.

Step 2D: Sum the total number of ED visits in the measurement year across all beneficiaries identified as eligible for each denominator group, respectively. The resulting number of ED visits is the numerator of the observed measure rate and is also the numerator of the ratio of observed-to-expected ED visits (used in the calculation of the risk-adjusted rate).

3. CALCULATING THE OBSERVED (UNADJUSTED) ED UTILIZATION RATE
States using the measure for internal quality improvement purposes and not intending to make any comparisons among the measure’s four denominator groups can calculate the unadjusted ED utilization rate as follows:

Step 3A: For each denominator group separately, divide the number of ED visits (from Step 2D) by the number of beneficiary months (from Step 1C), and multiply the resulting ratio by 1,000, as follows:

\[(\text{Number of ED visits}/\text{Number of beneficiary months}) \times 1,000 = \text{observed ED utilization rate}\]

For all other purposes, states should use the risk-adjusted measure rate (following steps 4-6).

4. RISK ADJUSTMENT: RISK FACTOR ASSIGNMENT
Step 4A: For each beneficiary, obtain values for each risk factor using the Risk Factor Weights tabs in the CCW Value Set Excel file, which contain detailed instructions for identifying the value of each risk factor to be applied with the associated weight in calculating the risk-adjusted measure. Note that the value set tables provide information on the period for which the CCW algorithms should be applied. Some conditions require applying the CCW algorithm to claims in both the lookback period and the measurement year; other conditions require applying the CCW algorithm only to the measurement year.

5. RISK ADJUSTMENT: WEIGHTING
To calculate the expected number of ED visits for each beneficiary, use the following steps to identify risk adjustment weights based on the risk factors. Risk adjustment raw coefficients are listed in the Risk Factor Raw Coefficients tabs in the CCW Value Set Excel file for each denominator group separately.

Step 5A: To identify the weight, multiply the value of each risk factor obtained for each beneficiary in Step 4A with the associated risk factor raw coefficient (e.g., if the beneficiary is female the risk factor value would be “1” and if the beneficiary is male the risk factor value would be “0”).

Step 5B: Identify the intercept weight, which is the same for every beneficiary within the same denominator group.
Step 5C: Sum all weights associated with the beneficiary (i.e., base, age, disability, sex, chronic conditions, and interaction risk factors).

Step 5D: Calculate the expected number of ED visits during the measurement year for a beneficiary eligible for any of the four denominator groups as follows: \( e^{\sum \text{weights}} = \# \text{ of expected ED visits.} \)

For example, for a male beneficiary age 50 with diabetes and depression, multiply the centered age weight by -8 (50 minus the mean age of beneficiaries in the eligible population); the centered age squared weight by 64 (-8 squared); the diabetes weight by 1; the depression weight by 1; the number of chronic conditions weight by 2; the number of MH conditions (squared) weight by 1; the number of physical and mental health conditions interaction weight by 1; and all other weights by 0. In this example, the expected number of ED visits during the measurement year for this beneficiary is: \( e^{-0.414} = 0.7 \) expected ED visits.

NOTE: The reference category for each factor has a value of zero for the included category of the risk factor. For example, beneficiaries who are male (the reference category for sex) would have a beneficiary value of 0 for the female category of the sex risk factor when computing the sum of coefficient estimates. Beneficiaries who are female (the included category for sex) would have a beneficiary value of 1 for the female category of the sex risk factor. Beneficiaries with a chronic condition would have a beneficiary value of 1 for that condition, and beneficiaries without the chronic condition would have a beneficiary value of 0 for that condition.

6. RISK ADJUSTMENT: REPORTING THE RISK-ADJUSTED ED UTILIZATION RATE

Perform the following steps to calculate the risk-adjusted ED utilization rate for each denominator group separately.

Step 6A: Sum the expected ED visits (from Step 5D) across all beneficiaries in the denominator group population.

Step 6B: Divide the state’s observed ED visit value (Step 2D) by the state’s expected ED visit value (Step 6A) to obtain the observed-to-expected (O/E) ratio.

Step 6C: To obtain the state’s risk-adjusted ED utilization rate, multiply the state’s O/E ratio by the observed rate across states; use the following observed rates across states:

- PH+MH: 209.2 all-cause ED visits per 1,000 beneficiary months
- PH+SUD: 283.3 all-cause ED visits per 1,000 beneficiary months
- MH+SUD: 263.4 all-cause ED visits per 1,000 beneficiary months
- SMI: 288.7 all-cause ED visits per 1,000 beneficiary months

The observed rate across states for each denominator group was calculated among the testing sample of 17 states and is intended to be used as a benchmark rate. These values will change over time and as the population characteristics of the measure’s denominator groups change.

\((\text{O/E for state}) \times (\text{observed rate across states}) = \text{risk-adjusted ED utilization rate for the state}\)

The resulting value will be in the form of number of ED visits per 1,000 beneficiary months.

120752 | 141015 | 113612

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3539e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

STEWARD
Centers for Medicare & Medicare Services

DESCRIPTION
Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy.

TYPE
Process

DATA SOURCE
Electronic Health Records Hospitals collect EHR data using certified electronic health record technology (CEHRT). The human readable format and XML are contained in the eCQM specifications attached in question S.2a. No additional tools are used for data collection for eMeasures.

LEVEL
Facility

SETTING
Inpatient/Hospital

NUMERATOR STATEMENT
Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.

NUMERATOR DETAILS
The time period for data collection is the measurement year (12-month period).
Numerator: Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.
Antipsychotic orders are represented with the QDM datatype and value set of Medication, Order: Antipsychotic Medications (OID:2.16.840.1.113883.3.464.1003.196.12.1255).
Numerator exclusions: Inpatient hospitalizations for patients with documented indication that they are threatening harm to self or others.
Threat to self or others is represented with the QDM datatype and value set of Symptom: Threat to themselves or others (OID:2.16.840.1.113883.3.464.1003.195.12.1020).
To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

DENOMINATOR STATEMENT
Non-psychiatric inpatient hospitalizations for patients who are 65 and older.

DENOMINATOR DETAILS
The time period for data collection is the measurement year (12-month period).

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by May 14, 2020 by 6:00 PM ET.
Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older. Inpatient hospitalizations are represented with the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID:2.16.840.1.113883.3.666.5.3001).

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

EXCLUSIONS

Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette’s syndrome, bipolar disorder, Huntington’s disease during the encounter.
Inpatient hospitalizations for patients who were taking antipsychotics prior to admission.

EXCLUSION DETAILS

The following data elements are used to define the measure exclusions:
Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette’s syndrome, bipolar disorder, Huntington’s disease during the encounter. These exclusions are represented with the QDM datatype of Diagnosis.
Schizophrenia or Psychotic Disorder (OID: 2.16.840.1.113883.3.464.1003.105.12.1104)
Tourette’s Syndrome (OID: 2.16.840.1.113883.3.464.1003.105.12.1030)
Bipolar Disorder (OID: 2.16.840.1.113883.3.67.1.101.1.128)
Huntington’s Disease (OID: 2.16.840.1.113883.3.464.1003.105.12.1032)
Denominator Exclusions: Inpatient hospitalizations for patients who were taking antipsychotics prior to admission.
Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255)
This exclusion is represented with the QDM datatype of Medication, Active:
Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255)
To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

RISK ADJUSTMENT

Stratification by risk category/subgroup

STRATIFICATION

Results include a total score and the following strata:
Stratum 1 - Patients who were admitted or transferred to the ICU during the inpatient encounter
Stratum 2 - Patients who were not admitted or transferred to the ICU during the inpatient encounter
These strata are identified using the QDM datatype of Encounter, Performed.
ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040)
To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.
TYPE SCORE
Rate/proportion better quality = lower score

ALGORITHM
See '1a__APLogic_Flow.pdf' submitted as an attachment under S.2a above.

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3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

STEWARD
Pharmacy Quality Alliance

DESCRIPTION
The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.

TYPE
Process

DATA SOURCE
Claims, Enrollment Data There is no data collection instrument. Individual health plans produce administrative claims in the course of providing care to health plan members.

This measure is being considered for use in the Quality Rating System (QRS) for Qualified Health Plans (QHPs). QHPs operate in the Health Insurance Exchanges, established by the Patient Protection and Affordable Care Act. As a condition of participation, eligible QHPs are required to collect and submit quality measure data. CMS calculates quality ratings based on the data submitted, and Exchanges are required to display QHP overall quality ratings and three summary indicator ratings to assist in consumer selection of a QHP offered on an Exchange.

The following sources of data were used to calculate the measure:
1. QHP products: Claims data from issuers, consisting of hospital and office visits, pharmacy, and laboratory claims (when available); enrollment data; and members’ demographic data OR
2. Medicare: Claims data from Medicare Parts A, B and D consisting of inpatient and outpatient claims and prescription drug events; enrollment data; and beneficiaries’ demographic data.

Please note that Medicare data were used to supplement QHP data for measure testing because they offer a robust sample for calculation of measure performance reliability. Medicare PDPs are similar to QHPs in that they are offered by private insurance companies and are responsible for providing safe and effective medication management. Additionally, if variation in performance is similar among QHP products and Medicare PDPs, we could conclude this measure is generally applicable and reliable at the health plan level. At the time this form was completed, CMS does not have a plan to add this measure to quality reporting or value-based purchasing programs for Medicare enrollees but may consider this measure for the future.

LEVEL
Health Plan

SETTING
Outpatient Services

NUMERATOR STATEMENT
Individuals in the denominator population who have not received a drug test during the measurement year.
NUMERATOR DETAILS

Individuals in the denominator who do not have at least one claim for a drug test during the measurement year will be counted in the numerator. The entire measurement year in which a member is continuously enrolled is used to calculate the measure.

A drug test is identified either through HCPCS drug test codes or through specified CPT or LOINC codes for presumptive or definitive drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids.

Qualifying CPT and HCPCS drug test codes, and suggested LOINC codes, are in the attached Excel file “AMO_CompleteCoding_UPDATED” in the following sheets: “Codes-2016 Data,” “Codes-2017 Data,” Codes-2018 Data,” and “DrugScreen_LOINC_15,16,17.”

DENOMINATOR STATEMENT

The target population for this measure is individuals 18 years of age and older and prescribed long-term opioid therapy during the measurement year. Individuals are excluded if they have had any claims indicating a cancer diagnosis or hospice care at any time during the measurement year.

DENOMINATOR DETAILS

The measurement year is defined as 12 consecutive months. Continuous enrollment is defined as 11 out of 12 months enrollment in a health plan in the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year. Long-term opioid therapy is defined as at least 90 days of cumulative days’ supply of any combination of opioid medications indicated for pain during the measurement period identified using prescription claims. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.

The target population is adults enrolled in a Qualified Health Plan (QHP) and on long-term opioid therapy.

Eligible members for this measure are those members who:
1) Are 18 years of age and older as of the first day of the measurement year.
2) Are continuously enrolled in a QHP which is defined as at least 11 out of 12 months during the measurement year or enrolled with no gaps until the date of death.
3) Have pharmacy claims indicating at least 90 days of cumulative supply of any combination of opioid medications indicated for pain during the measurement year.

Opioid medications are specified in the attached Excel file “AMO_CompleteCoding_UPDATED” in the following sheets “2016_OPIOIDFORPAINMEDICATION,” “2017_OPIOIDFORPAINMEDICATION,” and “2018_OPIOIDFORPAINMEDICATION.”

Days’ supply is calculated by summing the days’ supply for every prescription during the measurement year for opioid medications indicated for pain from the above lists. Individuals qualify for the measure denominator if this sum is at least 90 days.

Note: The active ingredient of the opioid medications is limited to formulations indicated for pain and delivered through any route except intravenous (IV) or epidural (EP). These two routes are not included in this measure because they are not commonly prescribed as chronic pain medications. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.
EXCLUSIONS

The measure excludes individuals with: 1) a diagnosis of cancer at any time during the measurement year; or 2) hospice care at any time during the year.

EXCLUSION DETAILS

Members with a diagnosis of cancer are identified with the diagnosis codes listed below.

Cancer exclusion ICD-9 codes (for testing only):
Include 140 through 239
Omit 173.XX series

Cancer exclusion ICD-10 codes:
Include C00 through D49
Omit C44.XX series

Members with hospice care are identified with the codes listed below.

Hospice Codes 2015-2016:
Revenue Codes – 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659
CPT Codes – 99377, 99378
HCPCS Codes – G0182, G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q50005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T043, T2044, T2045, T2046

Note: A full list of codes is provided in the attached Excel file “AMO_CompleteCoding” in the sheet “Codes-2016 Data,” “Codes-2017 Data,” and “Codes-2018 Data.”

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

Denominator: Individuals 18 years of age and older who are on long-term opioid therapy during the measurement year.

Create Denominator:
1. Include all individuals enrolled in a health plan for 11 of 12 months during the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year.
   a. For QHPs in the Health Insurance Marketplace, switching between QHP products is considered continuous enrollment if enrollment and claims/encounter data are available for 11 of 12 months. The measure score is attributed to the last enrolled QHP product, in accordance with...

2. Include individuals from step 1 who were 18 years of age or older as of the first day of the measurement year.

3. Include individuals from step 2 with a total days’ supply of opioids of 90 days or more identified in pharmacy claims (section S.7).

4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9).

5. Exclude individuals with any institutional or non-institutional claims indicating hospice care during the measurement year (section S.9).

6. Include only unique members from step 5 in the final denominator.

Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year.

Create Numerator:

7. Include individuals from the denominator who do not have any claims for a drug test during the measurement year (section S.5)

Calculate Measure Score:

8. The measure score is calculated as the number of individuals in the numerator divided by the number of individuals in the denominator multiplied by 100 (to produce a percentage).

For the Health Insurance Marketplace, members are attributed to the last QHP enrolled product during the measurement year. 135614

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## Appendix E: Related and Competing Measures (Tabular)

### Comparison of NQF #2800 and NQF #1932

<table>
<thead>
<tr>
<th></th>
<th>2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics</th>
<th>1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steward</strong></td>
<td>National Committee for Quality Assurance</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.</td>
<td>The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.</td>
</tr>
<tr>
<td><strong>Type</strong></td>
<td>Process</td>
<td>Process</td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Claims This measure is part of the Healthcare Effectiveness Data and Information Set (HEDIS). This measure pulls from administrative claims collected in the course of providing care to health plan members. NCQA collects the HEDIS data for this measure directly from health plans via NCQA’s online data submission system. No data collection instrument provided. Attachment 2800_APM_Value_Sets_Fall_2019.xlsx</td>
<td>Claims This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA’s online data submission system. No data collection instrument provided. Attachment 1932_SSD_Value_Sets.xlsx</td>
</tr>
<tr>
<td><strong>Level</strong></td>
<td>Health Plan</td>
<td>Health Plan, Integrated Delivery System, Population : Regional and State</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Emergency Department and Services, Outpatient Services</td>
<td>Other, Outpatient Services Any outpatient setting represented with Medicaid claims data</td>
</tr>
<tr>
<td><strong>Numerator Statement</strong></td>
<td>Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.</td>
<td>Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.</td>
</tr>
<tr>
<td><strong>Numerator Details</strong></td>
<td>Three numerators are reported using administrative data: 1. Children and adolescents 1-17 years of age on antipsychotics who received blood glucose testing during the measurement year. 2. Children and adolescents 1-17 years of age on antipsychotics who received cholesterol testing during the measurement year. 3. Children and adolescents on antipsychotics who received blood glucose and cholesterol testing during the measurement year. Blood Glucose Testing: one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result)</td>
<td>A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.</td>
</tr>
</tbody>
</table>
### 2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics

- Blood Glucose and Cholesterol Testing: both of the following during the measurement year on the same or different dates of service.
  - At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
  - At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

See attachment for all value sets referenced above.

### Denominator Statement

*Children and adolescents 1-17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions).*

### Denominator Details

*Children and adolescents age 1-17 years as of December 31 of the measurement year who had at least two antipsychotic medication dispensing events (Table APM-A) of the same or different medications, on different dates of service during the measurement year, with no more than one gap in enrollment of up to 45 days during the measurement year.*

**TABLE APM-A: ANTIPSYCHOTIC MEDICATIONS**

<table>
<thead>
<tr>
<th>DESCRIPTION / PRESCRIPTION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antipsychotic agents / Aripiprazole; Asenapine; Brexpiprazole; Cariprazine; Clozapine; Haloperidol; Iloperidone; Loxapine; Lurisadone; Molindone; Olanzapine; Paliperidone; Pimozide; Quetiapine; Quetiapine fumarate, Risperidone, Ziprasidone Phenothiazine antipsychotics / Chlorpromazine; Fluphenazine; Perphenazine; Thoridazine; Trifluoperazine Thioxanthenes / Thiothixene</td>
<td></td>
</tr>
</tbody>
</table>

### 1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

- Follow the steps below to identify the eligible population.

- Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

  - At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
    - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
    - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
    - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set.
    - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.
<table>
<thead>
<tr>
<th>2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics</th>
<th>1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</th>
</tr>
</thead>
</table>
| Long-acting injections / Aripiprazole; Fluphenazine decanoate; Haloperidol decanoate; Olanzapine; Paliperidone palmitate; Risperidone Psychotherapeutics combinations / Fluoxetine-olanzapine; Perphenazine-amitriptyline Phenothiazine antipsychotics / Prochlorperazine | - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set.  
- BH Acute Inpatient Value Set with Other Bipolar Disorder Value Set.  
  • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:  
  - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.  
  - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.  
  - ED Value Set with Schizophrenia Value Set.  
  - BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.  
  - BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.  
  - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.  
  • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:  
  - BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.  
  - BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set.  
  - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.  
  - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set.  
  - ED Value Set with Bipolar Disorder Value Set.  
  - ED Value Set with Other Bipolar Disorder Value Set. |
<table>
<thead>
<tr>
<th>2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics</th>
<th>1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</th>
</tr>
</thead>
</table>
| - BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set.  
- BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set.  
- BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.  
- BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.  
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set.  
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set. (See corresponding Excel document for the above value sets) | Exclusions  
Patients in hospice.  
Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.  
Exclude patients with diabetes during the measurement year or the year prior to the measurement year.  
Exclude patients who had no antipsychotic medications dispensed during the measurement year. |
| Exclusion Details  
Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Encounter Value Set or Hospice Intervention Value Set). See corresponding Excel file for value sets referenced above. | Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. |
<table>
<thead>
<tr>
<th>2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics</th>
<th>1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List).</td>
<td></td>
</tr>
<tr>
<td>Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).</td>
<td></td>
</tr>
<tr>
<td>- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.</td>
<td></td>
</tr>
<tr>
<td>- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).</td>
<td></td>
</tr>
<tr>
<td>PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):</td>
<td></td>
</tr>
<tr>
<td>- Alpha-glucosidase inhibitors: Acarbose, Miglitol</td>
<td></td>
</tr>
<tr>
<td>- Amylin analogs: Pramlinitide</td>
<td></td>
</tr>
<tr>
<td>- Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled</td>
<td></td>
</tr>
<tr>
<td>2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
<td>1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Meglitinides: Nateglinide, Repaglinide</td>
<td>Glucagon-like peptide-1 (GLP1) agonists: Dulaglutide, Exenatide, Liraglutide, Albiglutide</td>
</tr>
<tr>
<td>Sodium glucose cotransporter 2 (SGLT2) inhibitor: Canagliflozin, Dapagliflozin, Empagliflozin</td>
<td>Sulfonylureas: Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide</td>
</tr>
<tr>
<td>Thiazolidinediones: Pioglitazone, Rosiglitazone</td>
<td>Dipeptidyl peptidase-4 (DDP-4) inhibitors: Alogliptin, Linagliptin, Saxagliptin, Sitagliptin</td>
</tr>
<tr>
<td>Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. - Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set). - Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis.</td>
<td></td>
</tr>
<tr>
<td>ANTIPSYCHOTIC MEDICATIONS: (Antipsychotic Medications List)</td>
<td>Miscellaneous antipsychotic agents: Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisdone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics: Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine</td>
<td>Thioxanthenes: Thiothixene</td>
</tr>
<tr>
<td><strong>2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics</strong></td>
<td><strong>1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>

**Risk Adjustment**
- No risk adjustment or risk stratification

**Stratification**
- Report two age stratifications and a total rate:
  - Children and adolescents 1-11 years of age as of December 31 of the measurement year.
  - Children and adolescents 12-17 years of age as of December 31 of the measurement year.
  - Total (the sum of the age stratifications).

**Type Score**
- Rate/proportion better quality = higher score

**Algorithm**
**STEP 1:** Determine the eligible population. To do so, identify patients who meet all the specified criteria.
- AGES: Children and adolescents 1-17 years of age as of December 31 of the measurement year.
- EVENT/DIAGNOSIS: Identify patients who had at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year. SEE S.7 for the list of antipsychotic medications.

**STEP 2:** Determine the numerator by identifying the number of patients in the eligible population who received blood glucose testing, cholesterol testing, or blood glucose testing and cholesterol testing.

**STEP 3:** Calculate the rate by dividing the numerator by the denominator.

**Submission items**
- 5.1 Identified measures: 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>5a.1 Are specs completely harmonized?</th>
<th>5a.2 If not completely harmonized, identify difference, rationale, impact:</th>
<th>5b.1 If competing, why superior or rationale for additive value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2800</td>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics</td>
<td>No</td>
<td>The Metabolic Monitoring for Children and Adolescents on Antipsychotics measure assesses metabolic monitoring during the measurement year among children and adolescents who are prescribed antipsychotics. This measure is related to measure #1932 but addresses a different target population and measure focus. Measure #1932 assesses whether adults with schizophrenia or bipolar disorder who were prescribed antipsychotics are screened for diabetes. Similar to the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure, this measure is specified for the health plan level and uses administrative claims as the data source. The measures have different target populations but a similar measure focus. Measure #1932 focuses on adults 18 to 64 years of age who have schizophrenia or bipolar disorder and who are prescribed antipsychotics. The Metabolic Monitoring for Children and Adolescents on Antipsychotics measure includes all children and adolescents up to 17 years of age who are prescribed antipsychotics and does not focus on any specific conditions. Measure #1932 is focused on diabetes screening by receipt of a glucose test. While the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure also includes assessing whether a glucose test was received, it additionally assesses whether a cholesterol test was received since the focus is not just diabetes screening. The two measures are aligned in the way glucose testing is identified and measured.</td>
<td>N/A</td>
</tr>
<tr>
<td>1932</td>
<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>1934</td>
<td>Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Data Source

<table>
<thead>
<tr>
<th>Type</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Source</td>
<td>Claims, Enrollment Data</td>
<td>There is no data collection instrument. Individual health plans produce administrative claims in the course of providing care to health plan members. This measure is being considered for use in the Quality Rating System (QRS) for Qualified Health Plans (QHPs). QHPs operate in the Health Insurance Exchanges, established by the Patient Protection and Affordable Care Act. As a condition of participation, eligible QHPs are required to collect and submit quality measure data. CMS calculates quality ratings based on the data submitted, and Exchanges are required to display QHP overall quality ratings and three summary indicator ratings to assist in consumer selection of a QHP offered on an Exchange.</td>
<td>Paper Medical Records Medical record abstraction tool</td>
<td>No data collection instrument provided</td>
<td>No data dictionary</td>
</tr>
</tbody>
</table>
The following sources of data were used to calculate the measure:

1. **QHP products**: Claims data from issuers, consisting of hospital and office visits, pharmacy, and laboratory claims (when available); enrollment data; and members’ demographic data.

2. **Medicare**: Claims data from Medicare Parts A, B and D consisting of inpatient and outpatient claims and prescription drug events; enrollment data; and beneficiaries’ demographic data.

Please note that Medicare data were used to supplement QHP data for measure testing because they offer a robust sample for calculation of measure performance reliability. Medicare PDPs are similar to QHPs in that they are offered by private insurance companies and are responsible for providing safe and effective medication management. Additionally, if variation in performance is similar among QHP products and Medicare PDPs, we could conclude this measure is generally applicable and reliable at the health plan level. At the time this form was completed, CMS does not have a plan to add this measure to quality reporting or value-based purchasing programs for Medicare enrollees but may...
<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Measure Description</th>
<th>Numerator Statement</th>
<th>Numerator Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3542: Outpatient Services</td>
<td>Individuals in the denominator who have not received a drug test during the measurement year.</td>
<td>Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer*</td>
<td>Any member in the denominator given a bowel regimen or there is documentation as to why this was not needed.</td>
</tr>
<tr>
<td>3543: Home Care, Inpatient/Hospital, Outpatient Services</td>
<td>Individuals in the denominator population who have not received a bowel regimen</td>
<td>Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer*</td>
<td>Any member in the denominator given a bowel regimen or there is documentation as to why this was not needed.</td>
</tr>
<tr>
<td>3544: Health Plan, Clinic</td>
<td>Individuals in the denominator who do not have at least one claim for a drug test during the measurement year will be counted in the numerator. The entire measurement year in which a member is continuously enrolled is used to calculate the measure. A drug test is identified either through HCPCS drug test codes or through specified CPT or QDM datatype and value</td>
<td>Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer*</td>
<td>Any member in the denominator given a bowel regimen (or one is already in place) defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why such a bowel regimen is not needed.</td>
</tr>
</tbody>
</table>

*Identification and prescription of opioids and benzodiazepines (COB)
LOINC codes for presumptive or definitive drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. Qualifying CPT and HCPCS drug test codes, and suggested LOINC codes, are in the attached Excel file "AMO_CompleteCoding_UPDATED" in the following sheets: "Codes-2016 Data," "Codes-2017 Data," Codes-2018 Data," and "DrugScreen_LOINC_15,1 6.17."

| Threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day’s claims then are summed to determine the total MED for that day. For each member in the denominator: 1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations: • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply) • MED Daily Dose per claim = [# of opioid dosage units per day] X [# mg opioid per dosage unit] X (MED conversion factor) 2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member; 3. Identify the days where the MED threshold is exceeded. 4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Table Opioid-A: Opioid Medications (MED conversion factor) buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator. To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day’s claims then are summed to determine the total MED for that day. For each member in the denominator: 1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations: • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply) • MED Daily Dose per claim = [# of opioid dosage units per day] X [# mg opioid per dosage unit] X (MED conversion factor) 2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. 3. Identify the days where the MED threshold is exceeded. 4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. 5. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique pharmacy providers associated with an opioid prescription claim. 6. From the members meeting the criteria for the sets of Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.112 S.2) and Medication, Discharge: Benzodiazepines (2.16.840.1.113762.1.4.112 S.1). Presence of an existing opioid and a new opioid or benzodiazepine prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.112 S.2) and Medication, Discharge: Benzodiazepines (2.16.840.1.113762.1.4.112 S.1). Presence of an existing benzodiazepine and a new opioid prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Benzodiazepines (2.16.840.1.113762.1.4.112 S.1) and Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.112 S.2). Presence of an existing benzodiazepine and an existing opioid prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Benzodiazepines (2.16.840.1.113762.1.4.112 S.1) and Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.112 S.2). Concurrent use of opioids and benzodiazepines: Step 1: From the denominator population, identify individuals with 2 or more prescriptions claims on unique 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 sum of the number of days (cumulative) during the measurement year with overlapping days’ supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year. Step 3: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator. Note: When identifying days’ supply for opioids (or benzodiazepines): • Exclude any days’ supply that occur after the end of the measurement year.
<table>
<thead>
<tr>
<th>3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)</th>
<th>2617: Patients Treated with an Opioid who are Given a Bowel Regimen</th>
<th>2940: Use of Opioids at High Dosage in Persons Without Cancer</th>
<th>2950: Use of Opioids from Multiple Providers in Persons Without Cancer</th>
<th>2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer</th>
<th>3316e: Safe Use of Opioids – Concurrent Prescribing</th>
<th>3389: Concurrent Use of Opioids and Benzodiazepines (COB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>fentanyl buccal or SL tablets, or lozenze/troche (0.13) fentanyl film or oral spray (0.18) fentanyl nasal spray (0.16) fentanyl patch (7.2) hydrocodone (1) hydromorphone (4) levorphanol (11) meperidine (0.1) methadone (3) morphine (1) oxycodone (1.5) oxymorphone (3) pentazocine (0.37) tapentadol (0.4) tramadol (0.1)</td>
<td>MED component of the numerator (4), calculate the number of unique prescribers associated with an opioid prescription claim. Of the members meeting the criteria for the MED component of the numerator (4), any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.</td>
<td>Table Opioid A: Opioid Medications (MED conversion factor)</td>
<td>Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). Presence of two or more existing opioids at discharge resulting in concurrent therapy is represented by QDM datatype and value set of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at <a href="https://vsac.nlm.nih.gov">https://vsac.nlm.nih.gov</a>.</td>
<td>Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.</td>
<td>• Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.</td>
<td></td>
</tr>
<tr>
<td>*Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations.</td>
<td>MED component of the numerator (4), calculate the number of unique prescribers associated with an opioid prescription claim. Of the members meeting the criteria for the MED component of the numerator (4), any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.</td>
<td>Table Opioid A: Opioid Medications (MED conversion factor)</td>
<td>Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). Presence of two or more existing opioids at discharge resulting in concurrent therapy is represented by QDM datatype and value set of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at <a href="https://vsac.nlm.nih.gov">https://vsac.nlm.nih.gov</a>.</td>
<td>Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. Table COB-B: Benzodiazepines: Alprazolam, chlordiazepoxide, clonazepam, diazepam, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam (note: excludes injectable formulations)</td>
<td>• Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.</td>
<td></td>
</tr>
<tr>
<td>Denominator Statement</td>
<td>The target population for this measure is individuals 18 years of age and older who are given a prescription for an opioid during the measurement year.</td>
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<td></td>
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</tr>
<tr>
<td>Vulnerable adults who</td>
<td>Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>are given a prescription for an opioid</td>
<td>Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.</td>
<td>Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients age 18 years and older prescribed an opioid or a benzodiazepine at discharge from a hospital-based encounter (inpatient stay less than or equal to 120 days or emergency department encounters, including observation stays) during the measurement period.</td>
<td>The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days’ supply is 15 or more days. Individuals with cancer or in hospice are excluded.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Denominator Details**

The measurement year is defined as 12 consecutive months. Continuous enrollment is defined as 11 out of 12 months enrollment in a health plan in the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year. Long-term opioid therapy is defined as at least 90 days of cumulative days’ supply of any combination of opioid medications indicated for pain during the measurement period identified using prescription claims. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.

The target population is adults enrolled in a Qualified Health Plan (QHP) and on long-term opioid therapy. Eligible members for this measure are those members who:

- All vulnerable adults >17 years old prescribed an opioid as:
  - An inpatient
  - A hospice patient (inpatient or outpatient)
  - A non-hospice outpatient in patients who are not already taking an opioid
  - “Vulnerable” is defined as any of the following:
    - >74 years of age
    - Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)
    - Poor prognosis/terminal illness defined as life expectancy of <6 months
    - Stage IV cancer
    - Patients receiving hospice care in any setting
- Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.
- Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Patients 18 years and older prescribed an opioid or a benzodiazepine at discharge from a hospital-based encounter (inpatient stay less than or equal to 120 days or emergency department encounters, including observation stays) during the measurement period.

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 with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days’ supply is 15 or more days. Use Table COB-A: Opioids, below, to identify the opioid medications for the measure.

**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...
1) Are 18 years of age and older as of the first day of the measurement year.
2) Are continuously enrolled in a QHP which is defined as at least 11 out of 12 months during the measurement year or enrolled with no gaps until the date of death.
3) Have pharmacy claims indicating at least 90 days of cumulative supply of any combination of opioid medications indicated for pain during the measurement year.

Opioid medications are specified in the attached Excel file “AMO_CompleteCoding_UPDATED” in the following sheets: “2016_OPIOIDFORPAINMEDICATION,” “2017_OPIOIDFORPAINMEDICATION,” and “2018_OPIOIDFORPAINMEDICATION.”

Days’ supply is calculated by summing the days’ supply for every prescription during the measurement year for opioid medications indicated for pain from the above lists. Individuals qualify for the measure denominator if this sum is at least 90 days.

Note: The active ingredient of the opioid medications is limited to formulations indicated for pain and delivered through any route except intravenous (IV) or epidural (EP). These two routes are not included at discharge from a qualifying encounter, not those patients who were given an opioid or benzodiazepine as part of their encounter treatment, are represented by the following QDM datatype and value sets:
- Medication, Discharge: Schedule II and Schedule III Opioids (OID: 2.16.840.1.113762.1.4.1125.2)
- Medication, Discharge: Benzodiazepines (OID: 2.16.840.1.113762.1.4.1125.1)

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

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 with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days’ supply is 15 or more days’ supply during the measurement year.

Step 4: Of those identified in step 3, 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).

Note: When identifying days’ supply for opioids:
- Exclude any days’ supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims 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.

Table COB-A: Opioids: buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone,
### Exclusions

The measure excludes individuals with: 1) a diagnosis of cancer at any time during the measurement year; or 2) hospice care at any time during the year.

<table>
<thead>
<tr>
<th>Exclusion Details</th>
<th>Denominator exclusions: The following encounters are excluded from the denominator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-hospital outpatients who are already taking an opioid at the time of the study period opioid prescription</td>
<td>- Encounters for patients with an active diagnosis of cancer during the encounter</td>
</tr>
<tr>
<td>Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.</td>
<td>- Encounters for patients who are ordered for palliative care during the encounter</td>
</tr>
<tr>
<td>Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19</td>
<td>- Inpatient encounters with length of stay greater than 120 days Denominator exceptions: None.</td>
</tr>
<tr>
<td>Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19</td>
<td></td>
</tr>
<tr>
<td>Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19</td>
<td></td>
</tr>
<tr>
<td>Active cancer diagnosis or palliative care order during the encounter are represented using the QDM datatype and following value sets:</td>
<td></td>
</tr>
<tr>
<td>Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice:</td>
<td></td>
</tr>
<tr>
<td>- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or</td>
<td></td>
</tr>
<tr>
<td>- Use place of service code 34 where a hospice indicator is not</td>
<td></td>
</tr>
</tbody>
</table>

### Exclusions

<table>
<thead>
<tr>
<th>Exclusion Details</th>
<th>Denominator exclusions: The following encounters are excluded from the denominator:</th>
</tr>
</thead>
<tbody>
<tr>
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<td>- Encounters for patients with an active diagnosis of cancer during the encounter</td>
</tr>
<tr>
<td>Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.</td>
<td>- Encounters for patients who are ordered for palliative care during the encounter</td>
</tr>
<tr>
<td>Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19</td>
<td>- Inpatient encounters with length of stay greater than 120 days Denominator exceptions: None.</td>
</tr>
<tr>
<td>Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19</td>
<td></td>
</tr>
<tr>
<td>Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19</td>
<td></td>
</tr>
<tr>
<td>Active cancer diagnosis or palliative care order during the encounter are represented using the QDM datatype and following value sets:</td>
<td></td>
</tr>
<tr>
<td>Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice:</td>
<td></td>
</tr>
<tr>
<td>- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or</td>
<td></td>
</tr>
<tr>
<td>- Use place of service code 34 where a hospice indicator is not</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>3617: Patients Treated with an Opioid who are Given a Bowel Regimen</td>
<td>to hospice patients treated in any setting. Non-hospice outpatients who are prescribed an opioid who may have been on an opioid in the past, but are not taking an opioid at the time of the study period opioid prescription are NOT excluded.</td>
</tr>
<tr>
<td>2940: Use of Opioids at High Dosage in Persons Without Cancer</td>
<td>ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b</td>
</tr>
<tr>
<td>2950: Use of Opioids from Multiple Providers in Persons Without Cancer</td>
<td>- Intervention, Order: Palliative care (2.16.840.1.113762.1.4.112.5.3) available (e.g. Commercial, Medicaid) Cancer exclusion: Exclude any individuals with cancer during the measurement year. To identify individuals with cancer: - Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S2.b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.5.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. - For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: <a href="https://www.cms.gov/Medicare/Health-Plans/MedicareAdvantageSpcRateStats/Risk-Adjustors.html">https://www.cms.gov/Medicare/Health-Plans/MedicareAdvantageSpcRateStats/Risk-Adjustors.html</a></td>
</tr>
<tr>
<td>2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer</td>
<td></td>
</tr>
<tr>
<td>3316e: Safe Use of Opioids – Concurrent Prescribing</td>
<td>Risk Adjustment No risk adjustment or risk stratification</td>
</tr>
<tr>
<td>3389: Concurrent Use of Opioids and Benzodiazepines (COB)</td>
<td>Risk Adjustment No risk adjustment or risk stratification</td>
</tr>
<tr>
<td>Type Score</td>
<td>Rate/proportion better quality = lower score</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------</td>
</tr>
</tbody>
</table>
| Stratification | Not applicable. | Create Denominator: | 18 years of age and older who are on long-term opioid therapy during the measurement year. | 1. Include all individuals enrolled in a health plan for 11 of 12 months during the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year. a. For QHPs in the Health Insurance Marketplace, switching between QHP products is considered continuous enrollment if enrollment and claims/encounter data are available for 11 of 12 months. The measure score is attributed to the last enrolled QHP product, in accordance with technical guidance specific to the Health Insurance Marketplace. | Step One: Identify vulnerable adults with a prescription for an opioid. | a. For each member in the numerator: a. Calculate the MDR for each opioid prescription claim during the measurement period, using the following equations: c. Any member with four or more unique pharmacy providers AND four or more opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15. | Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the numerator and denominator logic is attached to the NQF submission form as a supplemental document in response to question A.1, "Opioids_LowFlow_for S.14 response.pdf". | 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. a. To be continuously enrolled, an individual may have no more than one 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,
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3517: Patients Treated with an Opioid who are Given a Bowel Regimen</td>
<td>2. Include only patients who are vulnerable (age &gt;74, VES-13 score &gt;2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9) 6. Include only unique members from step 5 in the final denominator. Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year. Create Numerator: opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.</td>
</tr>
<tr>
<td>2940: Use of Opioids at High Dosage in Persons Without Cancer</td>
<td>2. Include only patients who are vulnerable (age &gt;74, VES-13 score &gt;2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9) 6. Include only unique members from step 5 in the final denominator. Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year. Create Numerator: opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.</td>
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<tr>
<td>2950: Use of Opioids from Multiple Providers in Persons Without Cancer</td>
<td>2. Include only patients who are vulnerable (age &gt;74, VES-13 score &gt;2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9) 6. Include only unique members from step 5 in the final denominator. Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year. Create Numerator: opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.</td>
</tr>
<tr>
<td>2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer</td>
<td>2. Include only patients who are vulnerable (age &gt;74, VES-13 score &gt;2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9) 6. Include only unique members from step 5 in the final denominator. Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year. Create Numerator: opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.</td>
</tr>
<tr>
<td>3216e: Safe Use of Opioids – Concurrent Prescribing</td>
<td>2. Include only patients who are vulnerable (age &gt;74, VES-13 score &gt;2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9) 6. Include only unique members from step 5 in the final denominator. Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year. Create Numerator: opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.</td>
</tr>
<tr>
<td>3389: Concurrent Use of Opioids and Benzodiazepines (COB)</td>
<td>2. Include only patients who are vulnerable (age &gt;74, VES-13 score &gt;2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care). 3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed. 4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9) 6. Include only unique members from step 5 in the final denominator. Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year. Create Numerator: opioid per dosage unit) X (MED conversion factor) b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member. c. Identify the days where the MED threshold is exceeded. d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Step Three: Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.</td>
</tr>
<tr>
<td>Measure ID</td>
<td>Measure Description</td>
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</tr>
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</tr>
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</tr>
<tr>
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</tr>
<tr>
<td>3389: Concurrent Use of Opioids and Benzodiazepines (COB)</td>
<td></td>
</tr>
</tbody>
</table>

7. Include individuals from the denominator who do not have any claims for a drug test during the measurement year (section 5.5).

8. The measure score is calculated as the number of individuals in the numerator divided by the number of individuals in the denominator multiplied by 100 (to produce a percentage). For the Health Insurance Marketplace, members are attributed to the last QHP enrolled product during the measurement year.

To identify individuals with cancer:
- Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
- For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgsSpecRateStats/Risk-Adjustors.html

Step 6: Exclude individuals with cancer or in hospice (Step 5) from those identified in Step 4. This is the denominator.

8. Numerator Population:
- Step 7: From the denominator population (from Step 6), identify individuals with 2 or more prescriptions claims on unique 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 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 sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year. Step 9: Count the number of individuals with concurrent use of opioids and benzodiazepines for 30 or more cumulative days. This is the numerator. Note: When identifying days' supply for opioids (or benzodiazepines):  
• Exclude any days' supply that occur after the end of the measurement year.  
• Multiple prescription opioid (or benzodiazepine) claims with overlap: For multiple prescription claims for opioids (or benzodiazepines) with overlapping days' supply, count each day in the | 3316e: Safe Use of Opioids — Concurrent Prescribing | 3389: Concurrent Use of Opioids and Benzodiazepines (COB) |
| 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) | 3517: Patients Treated with an Opioid who are Given a Bowel Regimen | 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 | 2956: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer | 3316e: Safe Use of Opioids — Concurrent Prescribing | 3389: Concurrent Use of Opioids and Benzodiazepines (COB) |
|  | | | | | | | |
### Table: Measured Opioid Use

<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3541</td>
<td>Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)</td>
</tr>
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<td>Use of Opioids at High Dosage in Persons Without Cancer</td>
</tr>
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<td>Use of Opioids from Multiple Providers in Persons Without Cancer</td>
</tr>
<tr>
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</tr>
<tr>
<td>3316e</td>
<td>Safe Use of Opioids — Concurrent Prescribing</td>
</tr>
<tr>
<td>3389</td>
<td>Concurrent Use of Opioids and Benzodiazepines (COB)</td>
</tr>
</tbody>
</table>

#### Submission Items

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Identified measures:</td>
</tr>
<tr>
<td>1617: Patients Treated with an Opioid who are Given a Bowel Regimen</td>
<td></td>
</tr>
<tr>
<td>2940: Use of Opioids at High Dosage in Persons Without Cancer</td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td>3389: Concurrent Use of Opioids and Benzodiazepines (COB)</td>
<td></td>
</tr>
</tbody>
</table>

**5a.1** Are specs completely harmonized? Yes

**5a.2** If not completely harmonized, identify difference, rationale, and impact:
- The PQA opioid measures (NQF # 2940, 2950, and 2951) use the same target population (denominator), and each have different areas of focus (numerator). The NCQA measurement year only once toward the denominator. There is no adjustment for early fills or overlapping days’ supply for opioids (or benzodiazepines).

**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.
### 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

**Difference, rationale, impact:** An environmental scan revealed related measures listed above, which share similar populations of interest (patients receiving opioids). NQF 1617 targets vulnerable adults given a new prescription for an opioid, and therefore has a different target population than the AMO measure. NQF 3316e is an eCQM that targets patients discharged from a hospital-based encounter, a different setting of care than the AMO measure. Harmonization of value sets has been addressed to the extent possible with related outpatient health plan measures, NQF 2940, 2950, 2951, and 3389, including the cancer and hospice exclusions and targeted opioid medications. The AMO measure’s area of focus (numerator) does not overlap with any existing measure, and its focus on drug tests for patients on long-term opioid therapy is unique. Therefore, while there are some related measures that evaluate similar target populations of patients receiving opioid therapy, the AMO measure is a new and evidence-based focus to empower health plans to address opioid misuse and opioid use disorder, and improve patient safety. Harmonization has been addressed to Key Palliative Measures Bundle was provided.

### 3617: Patients Treated with an Opioid who are Given a Bowel Regimen

### 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

### 3316e: Safe Use of Opioids – Concurrent Prescribing

### 3389: Concurrent Use of Opioids and Benzodiazepines (COB)

With these PQA measures as they do not include benzodiazepines in the measure focus. Below we describe the differences between the proposed measure and NQF #2940, #2950, and #2951: The eligible population for the Concurrent Prescribing measure captures not only patients prescribed at least one opioid at discharge, but also patients prescribed at least one benzodiazepine at discharge per the measure focus. Experts stressed the importance of including both opioids and benzodiazepines in the denominator to ensure that the measure takes into consideration any iatrogenic risk from co-prescribing for both populations already on opioids or benzodiazepines; Only Schedule II and Schedule III opioids are in scope of the Concurrent Prescribing measure per expert consensus. The PQA measures also include Schedule IV opioids; The Concurrent Prescribing measure assesses patients across the hospital inpatients and outpatient settings (ED, including observation stays) per the programs in which the measure will be proposed for implementation. The PQA measure focuses on the prescription drug health plan level.

**5b.1 If competing, why superior or rationale for additive value:** Not applicable

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.1 If competing, why superior or rationale for additive value:** There are no competing measures (i.e., those that addresses both the same measure focus and the same target population).
<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)</td>
<td></td>
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<tr>
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</tbody>
</table>

the extent possible, and PQA will continue to identify and address opportunities to harmonize with related measures over time.

5b.1 If competing, why superior or rationale for additive value: Not applicable.
Comparison of NQF #3541 and NQF #1617, #2940, #2950, #2951, #3316, #3389

<table>
<thead>
<tr>
<th>Type</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
<th>Process</th>
</tr>
</thead>
</table>
| Data Source | Claims: Enrollment Data There is no data collection instrument. Individual health plans produce administrative claims in the course of providing care to health plan members. This measure is being considered for use in the Quality Rating System (QRS) for Qualified Health Plans (QHPs). QHPs operate in the Health Insurance Exchanges, established by the Patient Protection and Affordable Care Act. As a condition of participation, eligible QHPs are required to collect and submit quality measure data. CMS calculates quality ratings based on the data submitted, and Exchanges are required to display QHP overall quality ratings and three summary indicator ratings to assist in consumer selection of a QHP offered on an Exchange. The following sources of data were used to calculate the measure:

1. QHP products: Claims data from issuers, consisting of hospital and office visits, pharmacy, and laboratory claims (when available); enrollment data; and members’ demographic data OR
2. Medicare: Claims data from Medicare Parts A, B and D consisting of inpatient and outpatient claims and prescription drug events; enrollment data; and beneficiaries’ demographic data. Please note that Medicare data were used to supplement QHP data for measure testing because they offer a robust sample for calculation of measure performance reliability. Medicare PDGs are similar to QHPs in that they are offered by private insurance companies and are responsible for providing safe and effective medication management. Additionally, if variation in performance is similar among QHP products and Medicare PDGs, we could conclude this measure is generally applicable and reliable at the health plan level. At the time this form was completed, CMS does not have a plan to add this measure to quality reporting or value-based purchasing programs for |

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<tr>
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<table>
<thead>
<tr>
<th>Numerator Statement</th>
<th>Numerator Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals in the denominator population who have not received a drug test during the measurement year.</td>
<td>Patients from the denominator who do not have at least one claim for a drug test during the measurement year will be counted in the numerator. The entire measurement year in which a member is continuously enrolled is used to calculate the measure. A drug test is identified either through HCPCS drug test codes or through specified CPT or LOINC codes for presumptive or definitive drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. Qualifying CPT and HCPCS drug test codes, and suggested LOINC codes, are in the attached Excel file “AMO_CompleteCoding UPDATED.xlsx” in the following sheets: “Codes-2016 Data,” “Codes-2017 Data,” “Codes-2018 Data,” and “DrugScreen_LOINC_15.16.17.”</td>
</tr>
</tbody>
</table>

**Patient Details**

- **Patients from the denominator given a bowel regimen (or one is already in place) defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet or documentation of why such a bowel regimen is not needed.**
  - **Patients from the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer.**
  - MED calculation is included in 5.6 Numerator Details

- **Any member in the denominator with an opioid prescription claim where the MED is greater than 120mg for 90 consecutive days or longer.**
  - MED calculation is included in 5.6 Numerator Details

- **Any member in the denominator who received opioid prescription claims from 4 or more prescribers AND 4 or more pharmacies.**
  - Patients prescribed two or more opioids or an opioid and benzodiazepine at discharge.

- **Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies.**
  - MED calculation is included in 5.6 Numerator Details

**Step 1:**

- **From the denominator population, identify individuals with 2 or more prescriptions claims on unique 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.**
3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

1617: Patients Treated with an Opioid who are Given a Bowel Regimen

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

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

3116e: Safe Use of Opioids – Concurrent Prescribing

3389: Concurrent Use of Opioids and Benzodiazepines (COB)

### Prescription Claim (See Appendix A)

The MEDI for each day's claims are summed to determine the total MEDI for that day. For each member in the denominator:
1. Calculate the MEDI for each opioid prescription claim during the measurement period, using the following equations:
   - $\# \text{ of Opioid Dosage Units per day} \times \text{(Opioid claim quantity)} / (\# \text{ of opioid dosage units per day}) \times X (\# \text{ mg opioid per dosage unit}) \times \text{(MED conversion factor)}$

2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MEDI for each member.

3. Identify the days where the MEDI threshold is exceeded.

4. Any member, for whom the MEDI threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Table Opioid A: Opioid Medications (MED conversion factor) buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dicyclomine (0.25) fentanyl buccal or SL tablets, or lozenge/troche (0.13) fentanyl film or oral spray (0.18)

5. Appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MEDI for each day's claims are summed to determine the total MEDI for that day. For each member in the denominator:
6. Calculate the MEDI for each opioid prescription claim during the measurement period, using the following equations:
   - $\# \text{ of Opioid Dosage Units per day} \times \text{(Opioid claim quantity)} / (\# \text{ of opioid dosage units per day}) \times X (\# \text{ mg opioid per dosage unit}) \times \text{(MED conversion factor)}$

7. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MEDI for each member.

8. Identify the days where the MEDI threshold is exceeded.

9. Any member, for whom the MEDI threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator. Table Opioid A: Opioid Medications (MED conversion factor) buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dicyclomine (0.25) fentanyl buccal or SL tablets, or lozenge/troche (0.13) fentanyl film or oral spray (0.18)

### Concurrent Opioid and Benzodiazepine Therapy

In concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2) and Medication, Discharge: Benzodiazepines (2.16.840.1.113762.1.4.1125.1) and Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). Presence of an existing benzodiazepine and a new opioid prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Benzodiazepines (2.16.840.1.113762.1.4.1125.1) and Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). Presence of an existing benzodiazepine and an existing opioid prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Benzodiazepines (2.16.840.1.113762.1.4.1125.1) and Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). Presence of two or more existing opioids at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2). To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/.
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<th>3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMU)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>fentanyl nasal spray</strong> (0.16)</td>
<td><strong>fentanyl patch</strong> (7.2)</td>
<td><strong>hydrocodone</strong> (1)</td>
<td><strong>hydromorphone</strong> (4)</td>
<td><strong>levorphanol</strong> (11)</td>
<td><strong>mepерidinе</strong> (0.1)</td>
<td><strong>methadone</strong> (3)</td>
</tr>
<tr>
<td><strong>morphine</strong> (1)</td>
<td><strong>opium</strong> (1)</td>
<td><strong>oxycodeine</strong> (1.5)</td>
<td><strong>oxymorphone</strong> (3)</td>
<td><strong>pentazocine</strong> (0.37)</td>
<td><strong>tapentadol</strong> (0.4)</td>
<td><strong>tramadol</strong> (0.1)</td>
</tr>
<tr>
<td><em>Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., Bunaval™, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys</em> (fentanyl transdermal patch) is also excluded as it is only for inpatient use; it is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)*</td>
<td></td>
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</tbody>
</table>

From the members meeting the criteria for the MED component of the numerator (4), the number of unique prescribers associated with an opioid prescription claim. 7. From the members meeting the criteria for the MED component of the numerator (4), any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.  

Table Opioid A: Opioid Medications (MED conversion factor) **buprenorphine patch** (12.6)  

**buprenorphine tab or film** (10)  

**butorphanol** (7)  

**codeine** (0.15)  

**dihydrocodeine** (0.25)  

**fentanyl buccal or ST tablets, or lozenzе/troche** (0.13)  

**fentanyl film or oral spray** (0.18)  

**fentanyl nasal spray** (0.16)  

**fentanyl patch** (7.2)  

**hydrocodone** (1)  

**hydromorphone** (4)  

**levorphanol** (11)  

**mepеридinе** (0.1)  

**methadone** (3)  

**morphine** (1)  

**opium** (1)  

**oxycodeine** (1.5)  

**oxymorphone** (3)  

**pentazocine** (0.37)  

**tapentadol** (0.4)  

**tramadol** (0.1)  

*Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., Bunaval™, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys*
Denominator Statement

The target population for this measure is individuals 18 years of age and older who are given a bowel regimen. Continuous enrollment is defined as at least 11 out of 12 months during the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year. Long-term opioid therapy is defined as at least 90 days of cumulative days’ supply of any combination of opioid medications indicated for pain during the measurement period identified using prescription claims. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.

The target population is adults enrolled in a Qualified Health Plan (QHP) and on long-term opioid therapy. Eligible members for this measure are those members who:
1) Are 18 years of age and older as of the first day of the measurement year.
2) Are continuously enrolled in a QHP which is defined as at least 11 out of 12 months during the measurement year or enrolled with no gaps until the date of death.
3) Have pharmacy claims indicating at least 90 days of cumulative supply of any combination of opioid medications indicated for pain during the measurement year.

Opioid medications are specified in the attached Excel file “AMO_CompleteCoding_Updated” in the following sheets:
- 2016_OPIOIDFORPAINMEDICATION,
- 2017_OPIOIDFORPAINMEDICATION,
- 2018_OPIOIDFORPAINMEDICATION.

Days’ supply is calculated by summing the days’ supply for which the sum of the days’ supply is greater than or equal to 15.

Denominator Details

The measurement year is defined as 12 consecutive months. Continuous enrollment is defined as 11 out of 12 months enrollment in a health plan in the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year. Long-term opioid therapy is defined as at least 90 days of cumulative days’ supply of any combination of opioid medications indicated for pain during the measurement period identified using prescription claims. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.

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1) Are 18 years of age and older as of the first day of the measurement year.
2) Are continuously enrolled in a QHP which is defined as at least 11 out of 12 months during the measurement year or enrolled with no gaps until the date of death.
3) Have pharmacy claims indicating at least 90 days of cumulative supply of any combination of opioid medications indicated for pain during the measurement year.

Opioid medications are specified in the attached Excel file “AMO_CompleteCoding_Updated” in the following sheets:
- 2016_OPIOIDFORPAINMEDICATION,
- 2017_OPIOIDFORPAINMEDICATION,
- 2018_OPIOIDFORPAINMEDICATION.

Days’ supply is calculated by summing the days’ supply for which the sum of the days’ supply is greater than or equal to 15.

All vulnerable adults >17 years old prescribed an opioid as:
- An inpatient
- A hospice patient (inpatient or outpatient)
- A non-hospital outpatient in patients who are not already taking an opioid

“Vulnerable” is defined as any of the following:
- >74 years of age
- Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2003)
- Poor prognosis/terminal illness defined as life expectancy of <6 months
- Stage IV cancer
- Patients receiving hospice care in any setting
- Patients receiving hospice care in any setting

Use Table COB-A: Opioids, below, to identify the opioid medications for the measure.

Inpatient Encounters are represented using the ODM datatype and value set of Encounter, Performed: Encounter Inpatient (OID: 2.16.840.1.113883.3.66.1.22.1)

Inpatient encounters are included in the measure based on encounter start and end dates. ED Encounters including observation stay are represented using the ODM datatype and value set of Encounter, Performed: Encounter ED and Observation Stay (OID: 2.16.840.1.113883.3.157.1002.81).

Patients with an opioid or a benzodiazepine active on admission and continued at discharge are represented by the following ODM datatype and value sets:
- Medication, Active: Schedule II and Schedule III Opioids (OID: 2.16.840.1.113762.1.4.1125.2)
- Medication, Active: Benzodiazepines (OID: 2.16.840.1.113762.1.4.1125.1)

Patients who received a new opioid or benzodiazepine prescription at discharge from a qualifying encounter, not those patients who were given an opioid or benzodiazepine as part of their encounter treatment, are represented by the following ODM datatype and value set.

The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days’ supply is 15 or more days.

The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days’ supply is 15 or more days.

Note: When identifying days’ supply for opioids:
prescribed as chronic pain medications. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.

Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator from the enrollment database.

Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator from the enrollment database.

Denominator exclusions: The following encounters are excluded from the denominator:

- Encounters for patients with an active diagnosis of cancer during the encounter
- Encounters for patients who are ordered for palliative care during the encounter
- Inpatient encounters with length of stay greater than 120 days Denominator exceptions: None.

Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.

Exclusion Details

Members with a diagnosis of cancer are identified with the diagnosis codes listed below. Cancer exclusion ICD-9 codes (for testing only):

Include 140 through 239

Omit 173.AX series

Cancer exclusion ICD-10 codes:

Include C00 through D49

Omit C44.XX series

Members with hospice care are identified with the codes listed below:

Hospice Codes 2015-2016: Revenue Codes – 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659

CPT Codes – 99377, 99378

HCPCS Codes – G0182, G9473, G9474, G9475, G9476, G9477, G9478, G9479, G5003, G5004, G5005, G5006, G5007, G5008, G5010, S5126, T2042, T043, T2044, T2045, T2046

Patients who are prescribed an opioid in the outpatient setting are excluded if they are NOT hospice patients AND at the time of the opioid prescription occurred during the study period, they were already taking an opioid. This exclusion does NOT apply to inpatients or to hospice patients treated in any setting. Non-hospice outpatients

Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19. C9 and 10 Codes to Identify Cancer: Please see attachment in S.2b

Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19. C9 and 10 Codes to Identify Cancer: Please see attachment in S.2b

Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice. Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19. C9 and 10 Codes to Identify Cancer: Please see attachment in S.2b

Active cancer diagnosis or palliative care order during the encounter are represented using the QDM datatype and following value sets:

- Diagnosis: Cancer (2.16.840.1.113883.3.526.3.1010)
- Intervention, Performed: Palliative care (2.16.840.1.113762.1.4.1125.3)
- Intervention, Order: Palliative care (2.16.840.1.113762.1.4.1125.3)

Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice:

- Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
- Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)

Cancer exclusion: Exclude any individuals with cancer during the measurement year. To identify individuals with cancer:

- Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010)
Note that edits placed in brackets \[\] identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for (standing [not prn]) opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid.

<table>
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<tr>
<th>Type Score</th>
<th>Rate/proportion better quality = lower score</th>
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<th>Rate/proportion better quality = lower score</th>
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</tr>
</thead>
</table>
| Algorithm            | Denominator: Individuals 18 years of age and older who are on long-term opioid therapy during the measurement year. Create Denominator:
  1. Include all individuals enrolled in a health plan for 11 of 12 months during the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year.
  a. For QHPs in the Health Insurance Marketplace, switching between QHP products is considered continuous enrollment if enrollment and claims/encounter data are available for 11 of 12 months. The measure score is attributed to the last enrolled QHP product, in accordance with technical guidance specific to the Health Insurance Marketplace Quality Rating System (QRS), available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments-HIPAAQRS/.

  Note that edits placed in brackets \[\] identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for (standing [not prn]) opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid.

  Step One: Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

  Step Two: Calculate the numerator by:
  a. Calculating the number of unique pharmacy providers associated with.

  Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the denominator and numerator logic is attached to the NQF submission form as a supplemental document in response to question 4.1, “Opioids_DrugFlow_for 5.14 response.pdf”.

  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 with 2 or more prescription claims for opioids on unique dates of service, for which the
2. Include individuals from step 1 who were 18 years of age or older as of the first day of the measurement year.
3. Include individuals from step 2 with a total days' supply of opioids of 90 days or more identified in pharmacy claims (section S.7).
4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9).
5. Exclude individuals with any institutional or non-institutional claims indicating hospice care during the measurement year (section S.9).
6. Include only unique members from step 5 in the final denominator.

Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year.
Create Numerator:
7. Include individuals from the denominator who do not have any claims for a drug test during the measurement year (section S.5).

Calculate Measure Score:
8. The measure score is calculated as the number of individuals in the numerator divided by the number of individuals in the denominator multiplied by 100 (to produce a percentage).

For the Health Insurance Marketplace, members are attributed to the last QHP enrolled product during the measurement year.

Store prescription medication in a safe and accessible location.

Step 1: Identify individuals meeting the following: any individual with a diagnosis of cancer (as defined by the ICD-10 codes), any individual with a diagnosis of hospice, and any individual with a diagnosis of a primary or secondary cancer.

Step 2: Include only individuals who were 18 years of age or older as of the first day of the measurement year.

Step 3: Include individuals from step 2 with a total days' supply of opioids of 90 days or more identified in pharmacy claims.

Step 4: Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year.

Step 5: Exclude individuals with any institutional or non-institutional claims indicating hospice care during the measurement year.

Step 6: Exclude individuals with cancer or in hospice during the measurement year.

For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCC) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/Risk-Adjustors.html.

Step 7: Exclude all individuals from the enrollment database, where available (e.g. Medicare); or
Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid).

To identify individuals with cancer:
Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCC) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvSpecRateStats/Risk-Adjustors.html.

Step 6: Exclude all individuals from the enrollment database, where available.

Step 7: Identify individuals with cancer or in hospice during the measurement year.
### 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMU)

1617: Patients Treated with an Opioid who are Given a Bowel Regimen

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3389: Concurrent Use of Opioids and Benzodiazepines (COB)

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<thead>
<tr>
<th>Submission items</th>
<th>5.1 Identified measures: 1617 : Patients Treated with an Opioid who are Given a Bowel Regimen</th>
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</thead>
<tbody>
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#### 5.1 Identified measures:

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Sa.1 Are specs completely harmonized?

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

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

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

5.1 Identified measures:

Sa.1 Are specs completely harmonized?

Sa.2 If not completely harmonized, identify difference, rationale, impact:
<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2940</td>
<td>Use of Opioids at High Dosage in Persons Without Cancer</td>
</tr>
<tr>
<td>2950</td>
<td>Use of Opioids from Multiple Providers in Persons Without Cancer</td>
</tr>
<tr>
<td>2951</td>
<td>Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer</td>
</tr>
<tr>
<td>3116e</td>
<td>Safe Use of Opioids – Concurrent Prescribing</td>
</tr>
<tr>
<td>3388</td>
<td>Concurrent Use of Opioids and Benzodiazepines (COB)</td>
</tr>
</tbody>
</table>

5a.1 Are specs completely harmonized? Yes
5b.1 If competing, why superior or rationale for additive value: This proposed measure is a new measure. The list of Schedule II and III opioids and denominator exclusions are harmonized, where feasible, with NQF-endorsed PQA measures #2940, #2950, and #2951. The measure specifications of the proposed measure are not completely harmonized with these PQA measures as they do not include benzodiazepines in the measure focus. Below we describe the differences between the proposed measure and NQF #2940, #2950, and #2951: The eligible population for the Concurrent Prescribing measure captures not only patients prescribed at least one opioid at discharge, but also patients prescribed at least one benzodiazepine at discharge per the measure focus. Experts stressed the importance of including both opioids and benzodiazepines in the denominator to ensure that the measure takes into consideration any iatrogenic risk from co-prescribing for both populations already on opioids or benzodiazepines; Only Schedule II and Schedule III opioids are in scope of the Concurrent Prescribing measure per expert consensus. The PQA measures also include Schedule IV opioids; The Concurrent Prescribing measure assesses patients across the hospital inpatients and outpatient settings (ED, including observation stays) per the programs in which the measure will be proposed for implementation. The PQA measure focuses on the prescription drug health plan level.
5b.1 If competing, why superior or rationale for additive value: Not applicable.
### Comparison of NQF #3539e and NQF #2993

<table>
<thead>
<tr>
<th></th>
<th>3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting</th>
<th>2993: Potentially Harmful Drug-Disease Interactions in the Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Steward</strong></td>
<td>Centers for Medicare &amp; Medicare Services</td>
<td>National Committee for Quality Assurance</td>
</tr>
</tbody>
</table>
| **Description**      | Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy. | The percentage of patients 65 years of age and older who have evidence of an underlying disease, condition or health concern and who are dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Four rates are reported for this measure:  
- Rate 1: The percentage of those with a history of falls that received a potentially harmful medication  
- Rate 2: The percentage of those with dementia that received a potentially harmful medication  
- Rate 3: The percentage of those with chronic kidney disease that received a potentially harmful medication  
- Rate 4: Total rate  
A lower rate represents better performance for all rates. |
| **Type**             | Process                                                                        | Process                                                      |
| **Data Source**      | Electronic Health Records Hospitals collect EHR data using certified electronic health record technology (CEHRT). The human readable format and XML are contained in the eCQM specifications attached in question S.2a. No additional tools are used for data collection for eMeasures.  
No data collection instrument provided  
Attachment AP_value_sets_codes.xlsx | Claims, Electronic Health Data, Electronic Health Records  
This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA’s online data submission system.  
No data collection instrument provided  
Attachment DDE_Value_Sets-63597952271911582.xlsx |
| **Level**            | Facility                                                                       | Health Plan, Integrated Delivery System                       |
| **Setting**          | Inpatient/Hospital                                                             | Outpatient Services                                           |
| **Numerator Statement** | Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter. | Numerator 1: Patients with a history of falls who received at least one potentially harmful medication from Table DDE-A or Table DDE-B  
Numerator 2: Patients with a diagnosis of dementia who received at least one potentially harmful medication from Table DDE-D  
Numerator 3: Patients with chronic kidney disease who received at least one potentially harmful medication from Table DDE-E |
### Numerator Details

The time period for data collection is the measurement year (12-month period). Numerator: Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter. Antipsychotic orders are represented with the QDM datatype and value set of Medication, Order: Antipsychotic Medications (OID:2.16.840.1.113883.3.464.1003.196.12.1255). Numerator exclusions: Inpatient hospitalizations for patients with documented indication that they are threatening harm to self or others. Threat to self or others is represented with the QDM datatype and value set of Symptom: Threat to themselves or others (OID:2.16.840.1.113883.3.464.1003.195.12.1020). To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

Rate 1 numerator: Dispensed an ambulatory prescription for an anticonvulsant, nonbenzodiazepine hypnotic, or SSRI (Table DDE-A), antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B) on or between the index episode start data and December 31 of the measurement year.

Rate 2 numerator: Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B), or H2 receptor antagonist or anticholinergic agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.

Rate 3 numerator: Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID (Table DDE-E) on or between the IESD and December 31 of the measurement year.

Rate 4 numerator: The sum of numerators 1, 2 and 3.

Note: Do not include denied claims.

---

Table DDE-A: Potentially Harmful Drugs – Rate 1

<table>
<thead>
<tr>
<th>Anticonvulsants:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine, Clobazam, Divalproex sodium, Ethosuximide, Ethotoin, Ezogabine, Felbamate, Fosphenytoin, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Mephobarbital, Methsuximide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine HCL, Topiramate, Valproate sodium, Valproic acid, Vigabatrin, Zonisamide</td>
</tr>
</tbody>
</table>

SSRIs:

- Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Setraline

---

Table DDE-B: Potentially Harmful Drugs – Rate 1 (History of Falls) and Rate 2 (Dementia)

<table>
<thead>
<tr>
<th>Antipsychotics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aripiprazole, Asenapine, Brexipiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Larsidon, Molindone, Olanzapine, Paliperidone, Perphenazine, Pimozide, Quetiapine, Risperidone, Thoridazine, Thiothixene, Trifluoperazine, Ziprasidone</td>
</tr>
</tbody>
</table>

---

NATIONAL QUALITY FORUM

NQF REVIEW DRAFT—Comments due by May 14, 2020 by 6:00 PM ET.
<table>
<thead>
<tr>
<th>3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting</th>
<th>2993: Potentially Harmful Drug-Disease Interactions in the Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benzodiazepine hypnotics:</strong> Alprazolam, Chlordiazepoxide products, Clonazepam, Clorazepate-Dipotassium, Diazepam, Estazolam, Flurazepam HCL, Lorazepam, Midazolam HCL, Oxazepam, Quazepam, Temazepam, Triazolam</td>
<td><strong>Nonbenzodiazepine hypnotics:</strong> Eszopiclone, Zaleplon, Zolpidem</td>
</tr>
<tr>
<td><strong>Tricyclic antidepressants:</strong> Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (&gt;6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine</td>
<td><strong>Tricyclic antidepressants:</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Table DDE-D: Potentially Harmful Drugs – Rate 2 (Dementia)</strong></td>
<td><strong>Table DDE-E: Cox-2 Selective NSAIDs and Nonaspirin NSAIDs</strong></td>
</tr>
<tr>
<td><strong>H2 receptor antagonists:</strong> Cimetidine, Famotidine, Nizatidine, Ranitidine</td>
<td><strong>Cox-2 Selective NSAIDs:</strong> Celecoxib</td>
</tr>
<tr>
<td><strong>Anticholinergic agents, antiemetics:</strong> Prochlorperazine, Promethazine</td>
<td><strong>Nonaspirin NSAIDs:</strong></td>
</tr>
<tr>
<td><strong>Anticholinergic agents, antihistamines:</strong> Carbinoxamine, Chlorpheniramine, Hydroxyzine products, Brompheniramine, Clemastine, Cyproheptadine, Promethazine, Triprolidine, Dimenhydrinate, Diphenhydramine, Meclizine, Dextromethorphan, Dextromethorphan, Nortriptyline, Trimipramine, Doxylamine</td>
<td></td>
</tr>
<tr>
<td><strong>Anticholinergic Agents, antimuscarinics (oral)</strong> Atropine, Homatropine, Belladonna alkaloids, Dicyclomine, Hyoscyamine, Propantheline, Scopolamine, Clidinium-chlordiazepoxide</td>
<td><strong>Anticholinergic agents, antimuscarinics (oral)</strong> Darifenacin, Fesoterodine, Solifenacin, Trosipramine, Flavoxate, Oxybutynin, Tolterodine</td>
</tr>
<tr>
<td><strong>Anticholinergic agents, anti-Parkinson agents</strong> Benztropine, Trihexyphenidyl</td>
<td><strong>Anticholinergic agents, anti-Parkinson agents</strong></td>
</tr>
<tr>
<td><strong>Anticholinergic agents, skeletal muscle relaxants</strong> Cyclobenzaprine, Orphenadrine</td>
<td><strong>Anticholinergic agents, SSRIs:</strong> Paroxetine</td>
</tr>
<tr>
<td><strong>Anticholinergic agents, SSRI:</strong> Anticholinergic agents, antiarrhythmic:</td>
<td><strong>Anticholinergic agents, antiarrhythmic:</strong> Disopyramide</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Table DDE-E: Cox-2 Selective NSAIDs and Nonaspirin NSAIDs</strong></td>
<td><strong>Table DDE-E: Cox-2 Selective NSAIDs and Nonaspirin NSAIDs</strong></td>
</tr>
<tr>
<td>Cox-2 Selective NSAIDs: Celecoxib</td>
<td>Nonaspirin NSAIDs:</td>
</tr>
<tr>
<td>Denominator Statement</td>
<td>Non-psychiatric inpatient hospitalizations for patients who are 65 and older.</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

| Denominator Details | The time period for data collection is the measurement year (12-month period). Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older. Inpatient hospitalizations are represented with the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID:2.16.840.1.113883.3.666.5.3001). To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. |

| Rate 1 denominator: Patients with an accidental fall or hip fracture (Note: hip fractures are used as a proxy for identifying accidental falls). Individuals with either of the following on or between January 1 of the year prior to the measurement year and December 1 of the measurement year meet criteria: |
| Rate 2 denominator: Patients with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication (Table DDE-C) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. |
| Rate 3 denominator: Patients with chronic kidney disease as identified by a diagnosis of ESRD (ESRD Value Set), stage 4 chronic kidney disease (CKD Stage 4 Value Set) or kidney transplant (Kidney Transplant Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. |
| Rate 4 denominator: The sum of the denominators for rates 1, 2 and 3 |

**3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**

- Diclofenac potassium, Diclofenac sodium, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Keterolac, Meflofenamate, Mefenamic acid, Meloxicam, Nabumetone, Naproxen, Naproxen sodium, Oxaprozin, Piroxicam, Sulindac, Tolmetin
<table>
<thead>
<tr>
<th>3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting</th>
<th>2993: Potentially Harmful Drug-Disease Interactions in the Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusions</strong></td>
<td>Note: Patients with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify). See S.2.b for all Value Sets</td>
</tr>
<tr>
<td>Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette’s syndrome, bipolar disorder, Huntington’s disease during the encounter. Inpatient hospitalizations for patients who were taking antipsychotics prior to admission.</td>
<td><strong>Table DDE-C: Prescriptions to Identify Members with Dementia</strong> Cholinesterase inhibitors: Donepezil, Galantamine, Rivastigmine Miscellaneous central nervous system agents: Memantine</td>
</tr>
<tr>
<td><strong>Exclusion Details</strong></td>
<td>The following are exclusions for the condition-specific rates and total rate: For those who meet denominator criteria for the history of falls rate (Rate 1): exclude those with a diagnosis of psychosis, schizophrenia, bipolar disorder or seizure disorder. For those who meet denominator criteria for those with dementia rate (Rate 2): exclude those with a diagnosis of psychosis, schizophrenia or bipolar disorder.</td>
</tr>
<tr>
<td>The following data elements are used to define the measure exclusions: Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette’s syndrome, bipolar disorder, Huntington’s disease during the encounter. These exclusions are represented with the QDM datatype of Diagnosis. Schizophrenia or Psychotic Disorder (OID: 2.16.840.1.113883.3.464.1003.105.12.1104) Tourette’s Syndrome (OID: 2.16.840.1.113883.3.464.1003.105.12.1030) Bipolar Disorder (OID: 2.16.840.1.113883.3.67.1.101.1.128) Huntington’s Disease (OID: 2.16.840.1.113883.3.464.1003.105.12.1032) Denominator Exclusions: Inpatient hospitalizations for patients who were taking antipsychotics prior to admission. Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255) This exclusion is represented with the QDM datatype of Medication, Active: Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255)</td>
<td>For those who meet denominator criteria for the history of falls rate (Rate 1): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set), bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) or seizure disorder (Seizure Disorders Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. For those who meet denominator criteria for those with dementia rate (Rate 2): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set) or bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. See S.2.b for all Value Sets</td>
</tr>
<tr>
<td>Measure</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 3539e   | Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting | To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at [https://vsac.nlm.nih.gov/](https://vsac.nlm.nih.gov/). A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. | No risk adjustment or risk stratification | Results include a total score and the following strata:  
Stratum 1 - Patients who were admitted or transferred to the ICU during the inpatient encounter  
Stratum 2 - Patients who were not admitted or transferred to the ICU during the inpatient encounter  
These strata are identified using the QDM datatype of Encounter, Performed. ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040) |
| 2993    | Potentially Harmful Drug-Disease Interactions in the Elderly | To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at [https://vsac.nlm.nih.gov/](https://vsac.nlm.nih.gov/). A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. | No risk adjustment or risk stratification | No risk adjustment or risk stratification |

### Risk Adjustment
- Stratification by risk category/subgroup
- No risk adjustment or risk stratification

### Stratification
- Results include a total score and the following strata:
  - **Stratum 1**: Patients who were admitted or transferred to the ICU during the inpatient encounter
  - **Stratum 2**: Patients who were not admitted or transferred to the ICU during the inpatient encounter
  - These strata are identified using the QDM datatype of Encounter, Performed.
  - ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040)

### Algorithm
- **Rate Score**: Better quality = lower score

**Step 1.** Determine the eligible population: All patients 67 years of age and older as of the end (i.e., December 31) of the measurement year.
**Step 2.** Identify the denominators for each of the four rates:
  - **Rate 1**: Those in the eligible population with a history of falls (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia, bipolar disorder, or seizure disorder (see S.11 for details). Identify the index episode start date.
  - **Rate 2**: Those in the eligible population with a dementia (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia or bipolar disorder (see S.11 for details). Identify the index episode start date.
<table>
<thead>
<tr>
<th>3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting</th>
<th>2993: Potentially Harmful Drug-Disease Interactions in the Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate 3: Those in the eligible population with end stage renal disease (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the index episode start date. Rate 4: The sum of denominators for Rates 1, 2 and 3. Step 3: Identify the numerators: Individuals in each of the denominators who have received at least one potentially harmful medication on or after the index episode start date (see definitions of potentially harmful medications for each numerator in section S.6). Step 4: Calculate the rates: Rate 1 – Numerator 1 divided by denominator 1. Rate 2 – Numerator 2 divided by denominator 2. Rate 3 – Numerator 3 divided by denominator 3. Rate 4 – The sum of the three numerators divided by the sum of the three denominators. Note: for this measure a lower rate indicates better performance for all four rates. Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year. For an outpatient claim/encounter, the IESD is the date of service. For an inpatient claim/encounter, the IESD is the discharge date. For dispensed prescriptions, the IESD is the dispense date.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Submission items</th>
<th>5.1 Identified measures: 0022 : Use of High-Risk Medications in the Elderly (DAE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5a.1 Are specs completely harmonized? Yes</td>
<td></td>
</tr>
<tr>
<td>5a.2 If not completely harmonized, identify difference, rationale, impact: These measures are harmonized to the extent possible. While all measures assess the potentially inappropriate use of antipsychotic medications, this is the only measure that assesses use of antipsychotic medications in the inpatient hospital setting. CMS N011.01 and CMS N031.02 are intended for use in the nursing home setting. Measures NQF 2111 and NQF 2993 assess health plan performance. This measure’s eligible population includes all patients in an inpatient hospital setting who are age 65 and older, which aligns with the age for</td>
<td></td>
</tr>
<tr>
<td>5a.1 Are specs completely harmonized? No</td>
<td></td>
</tr>
<tr>
<td>5a.2 If not completely harmonized, identify difference, rationale, impact: This measure and NQF 0022 have a similar focus (measuring potentially inappropriate medication use in the elderly) and reporting level (health plan), however they have different target populations. This measure targets patients with a specific condition or disease that can experience adverse effects when combined with certain medications that are recommended to be avoided for that condition. NQF 0022 targets a larger population of all older adults and assesses</td>
<td></td>
</tr>
<tr>
<td>3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting</td>
<td>2993: Potentially Harmful Drug-Disease Interactions in the Elderly</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| measures NQF 2111 and NQF 2993. NQF 2111 and NFQ 2993 only assess older adults with dementia, whereas this measure includes all older adults. The denominator exclusions are similar across measures. The exclusions in this measure—schizophrenia (including psychotic disorders), Tourette’s syndrome, Huntington’s disease, and bipolar disorder—are similar to exclusions in related measures. CMS N011.01, CMS N031.02, and NQF 2111 exclude patients with schizophrenia, Tourette’s syndrome, or Huntington’s disease. NQF 2111 also excludes patients with bipolar disorder. NQF 2993 excludes patients with psychosis, schizophrenia, or bipolar disorder. This measure also excludes from the numerator people in the inpatient setting who are identified as a threat to themselves or others. No other measure excludes these patients, although this exclusion is appropriate for the hospital setting. The specific antipsychotic medications included in each measure are aligned.  

5b.1 If competing, why superior or rationale for additive value: Not applicable. | use of high-risk medications that have been recommended to be avoided in all older adults.  

5b.1 If competing, why superior or rationale for additive value: N/A |
Appendix E: Related and Competing Measures (Narrative)

Behavioral Health and Substance Use, Fall 2019 Cycle: CDP Report Behavioral Health and Substance Use, Fall 2019 Cycle: CDP Report Comparison of NQF #3541 and NQF #1617, #2940, #2950, #2951, #3316, #3389

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
1617: Patients Treated with an Opioid who are Given a Bowel Regimen
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
3316e: Safe Use of Opioids – Concurrent Prescribing
3389: Concurrent Use of Opioids and Benzodiazepines (COB)

Steward

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Pharmacy Quality Alliance

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
RAND Corporation/UCLA

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

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

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

3316e: Safe Use of Opioids – Concurrent Prescribing
Centers for Medicare & Medicaid Services

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
PQA, Inc.

Description

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
The percentage of individuals 18 years of age and older who are on long-term opioid therapy and have not received a drug test at least once during the measurement year.

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed

2940: Use of Opioids at High Dosage in Persons Without Cancer
The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.
2950: Use of Opioids from Multiple Providers in Persons Without Cancer
The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

3316e: Safe Use of Opioids – Concurrent Prescribing
Patients age 18 years and older prescribed two or more opioids or an opioid and benzodiazepine concurrently at discharge from a hospital-based encounter (inpatient or emergency department [ED], including observation stays)

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
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.

Type

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Process

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Process

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

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

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

3316e: Safe Use of Opioids – Concurrent Prescribing
Process

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
Process

Data Source

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Claims, Enrollment Data There is no data collection instrument. Individual health plans produce administrative claims in the course of providing care to health plan members. This measure is being considered for use in the Quality Rating System (QRS) for Qualified Health Plans (QHPs). QHPs operate in the Health Insurance Exchanges, established by the Patient Protection and Affordable Care Act. As a condition of participation, eligible QHPs are required to collect and submit quality measure data. CMS calculates quality ratings
based on the data submitted, and Exchanges are required to display QHP overall quality ratings and three summary indicator ratings to assist in consumer selection of a QHP offered on an Exchange.

The following sources of data were used to calculate the measure:

1. QHP products: Claims data from issuers, consisting of hospital and office visits, pharmacy, and laboratory claims (when available); enrollment data; and members’ demographic data OR

2. Medicare: Claims data from Medicare Parts A, B and D consisting of inpatient and outpatient claims and prescription drug events; enrollment data; and beneficiaries’ demographic data.

Please note that Medicare data were used to supplement QHP data for measure testing because they offer a robust sample for calculation of measure performance reliability. Medicare PDPs are similar to QHPs in that they are offered by private insurance companies and are responsible for providing safe and effective medication management. Additionally, if variation in performance is similar among QHP products and Medicare PDPs, we could conclude this measure is generally applicable and reliable at the health plan level. At the time this form was completed, CMS does not have a plan to add this measure to quality reporting or value-based purchasing programs for Medicare enrollees but may consider this measure for the future.

No data collection instrument provided Attachment AMO_CompleteCoding_UPDATED-637002672397479085.xlsx

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
   Paper Medical Records Medical record abstraction tool
   No data collection instrument provided No data dictionary

2940: Use of Opioids at High Dosage in Persons Without Cancer
   Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.
   No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes.xlsx

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
   Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.
   No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes-635969250747751020.xlsx

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
   Claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.
   No data collection instrument provided Attachment Cancer_Exclusion_RxHCC-_ICD-9_and_10_Codes-635969265833553126.xlsx

3316e: Safe Use of Opioids – Concurrent Prescribing
   Electronic Health Records Hospitals collect EHR data using certified electronic health record technology (CEHRT). The human readable and XML artifacts of the health quality
measures format (HQMF) of the measure are contained in the eCQM specifications attached in question S.2a. No additional tools are used for data collection for eCQMs. No data collection instrument provided Attachment Opioids_ValueSets.xlsx

**3389: Concurrent Use of Opioids and Benzodiazepines (COB)**
Claims Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs)
No data collection instrument provided Attachment PQA_ICD_Code_Cancer_Value_Set_Feb_2018.xlsx

**Level**

**3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)**
Health Plan

**1617: Patients Treated with an Opioid who are Given a Bowel Regimen**
Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual

**2940: Use of Opioids at High Dosage in Persons Without Cancer**
Health Plan, Other, Population : Regional and State

**2950: Use of Opioids from Multiple Providers in Persons Without Cancer**
Health Plan, Other, Population : Regional and State

**2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer**
Health Plan, Other, Population : Regional and State

**3316e: Safe Use of Opioids – Concurrent Prescribing**
Facility

**3389: Concurrent Use of Opioids and Benzodiazepines (COB)**
Health Plan

**Setting**

**3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)**
Outpatient Services

**1617: Patients Treated with an Opioid who are Given a Bowel Regimen**
Home Care, Inpatient/Hospital, Outpatient Services

**2940: Use of Opioids at High Dosage in Persons Without Cancer**
Other, Outpatient Services 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.

**2950: Use of Opioids from Multiple Providers in Persons Without Cancer**
Other, Outpatient Services 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.
2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Other, Outpatient Services 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.

3316e: Safe Use of Opioids – Concurrent Prescribing
Emergency Department and Services, Inpatient/Hospital

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
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.

Numerator Statement

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Individuals in the denominator population who have not received a drug test during the measurement year.

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed

2940: Use of Opioids at High Dosage in Persons Without Cancer
Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer*
*MED calculation is included in S.6 Numerator Details

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
Any member in the denominator who received opioid prescription claims from 4 or more prescribers AND 4 or more pharmacies.

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Any member in the denominator with opioid prescription claims where the MED is greater than 120mg for 90 consecutive days or longer* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies.
*MED calculation is included in S.6 Numerator Details

3316e: Safe Use of Opioids – Concurrent Prescribing
Patients prescribed two or more opioids or an opioid and benzodiazepine at discharge.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
The number of individuals from the denominator with concurrent use of opioids and benzodiazepines for 30 or more cumulative days during the measurement year.

Numerator Details

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Individuals in the denominator who do not have at least one claim for a drug test during the measurement year will be counted in the numerator. The entire measurement year in which a member is continuously enrolled is used to calculate the measure.
A drug test is identified either through HCPCS drug test codes or through specified CPT or LOINC codes for presumptive or definitive drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids.

Qualifying CPT and HCPCS drug test codes, and suggested LOINC codes, are in the attached Excel file “AMO_CompleteCoding_UPDATED” in the following sheets: “Codes-2016 Data,” “Codes-2017 Data,” “Codes-2018 Data,” and “DrugScreen_LOINC_15,16,17.”

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Patients from the denominator given a bowel regimen (or one is already in place) defined as an offer/prescription of a laxative, stool softener, or high fiber supplement/diet OR documentation of why such a bowel regimen is not needed.

2940: Use of Opioids at High Dosage in Persons Without Cancer
Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer* (See Table Opioids-A: Opioid Medications)

*Identifying members with prescription opioids that exceeded the MED threshold:

To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day's claims then are summed to determine the total MED for that day.

For each member in the denominator:
1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:
   - # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)
   - MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)
2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.
3. Identify the days where the MED threshold is exceeded.
4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Table Opioid-A: Opioid Medications (MED conversion factor)

<table>
<thead>
<tr>
<th>Opioid Product</th>
<th>MED Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>buprenorphine patch (12.6)</td>
<td></td>
</tr>
<tr>
<td>buprenorphine tab or film (10)</td>
<td></td>
</tr>
<tr>
<td>butorphanol (7)</td>
<td>10</td>
</tr>
<tr>
<td>codeine (0.15)</td>
<td></td>
</tr>
<tr>
<td>dihydrocodeine (0.25)</td>
<td></td>
</tr>
<tr>
<td>fentanyl buccal or SL tablets, or lozenges/troche (0.13)</td>
<td></td>
</tr>
<tr>
<td>fentanyl film or oral spray (0.18)</td>
<td></td>
</tr>
<tr>
<td>fentanyl nasal spray (0.16)</td>
<td></td>
</tr>
<tr>
<td>fentanyl patch (7.2)</td>
<td></td>
</tr>
<tr>
<td>hydromorphone (4)</td>
<td></td>
</tr>
<tr>
<td>levorphanol (11)</td>
<td></td>
</tr>
<tr>
<td>meperidine (0.1)</td>
<td></td>
</tr>
<tr>
<td>methadone (3)</td>
<td></td>
</tr>
<tr>
<td>morphine (1)</td>
<td></td>
</tr>
<tr>
<td>opium (1)</td>
<td></td>
</tr>
<tr>
<td>oxycodone (1.5)</td>
<td></td>
</tr>
<tr>
<td>oxymorphone (3)</td>
<td></td>
</tr>
<tr>
<td>pentazocine (0.37)</td>
<td></td>
</tr>
<tr>
<td>tapentadol (0.4)</td>
<td></td>
</tr>
<tr>
<td>tramadol (0.1)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., BupavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)
2950: Use of Opioids from Multiple Providers in Persons Without Cancer

For each member in the denominator:

1. Calculate the number of unique pharmacy providers associated with an opioid prescription claim.
2. Calculate the number of unique prescribers associated with an opioid prescription claim.
3. Any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

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

Any member in the denominator with opioid prescription claims greater than 120mg MED for 90 consecutive days or longer* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies (See Table Opioids-A: Opioid Medications)

*Identifying members with prescription opioids that exceeded the MED threshold:

To identify members with prescription opioids that exceeded the MED threshold, each claim is to be converted into the MED using the appropriate conversion factor associated with the opioid product of that prescription claim (see Appendix A). The MED for each day’s claims then are summed to determine the total MED for that day.

For each member in the denominator:

1. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:
   • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)
   • MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)
2. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.
3. Identify the days where the MED threshold is exceeded.
4. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.
5. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique pharmacy providers associated with an opioid prescription claim.
6. From the members meeting the criteria for the MED component of the numerator (4), calculate the number of unique prescribers associated with an opioid prescription claim.
7. From the members meeting the criteria for the MED component of the numerator (4), any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

Table Opioid-A: Opioid Medications (MED conversion factor)

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>MED Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>buprenorphine patch (12.6)</td>
<td>buprenorphine tab or film (10)</td>
</tr>
<tr>
<td>butorphanol (7)</td>
<td>codeine (0.15)</td>
</tr>
<tr>
<td>dihydrocodeine (0.25)</td>
<td>fentanyl buccal or SL tablets, or lozenge/troche (0.13)</td>
</tr>
<tr>
<td>fentanyl film or oral spray (0.18)</td>
<td>fentanyl nasal spray (0.16)</td>
</tr>
<tr>
<td>fentanyl patch (7.2)</td>
<td>hydromorphone (4)</td>
</tr>
<tr>
<td>levorphanol (11)</td>
<td>meperidine (0.1)</td>
</tr>
<tr>
<td>morphine (1)</td>
<td>methadone (3)</td>
</tr>
<tr>
<td>opium (1)</td>
<td>oxycodone (1.5)</td>
</tr>
<tr>
<td>oxymorphone (3)</td>
<td>pentazocine (0.37)</td>
</tr>
<tr>
<td>tapentadol (0.4)</td>
<td>tramadol (0.1)</td>
</tr>
</tbody>
</table>
*Note: Injectables and Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., Bunavail™, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys® (fentanyl transdermal patch) is also excluded as it is only for inpatient use; It is also only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS)

3316e: Safe Use of Opioids – Concurrent Prescribing

Presence of two or more new opioids at discharge resulting in concurrent therapy is represented by QDM datatype and value set of Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2).

Presence of a new opioid and a new benzodiazepine prescription at discharge resulting in concurrent therapy is represented by QDM datatype and value sets of Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2) and Medication, Discharge: Benzodiazepines (2.16.840.1.113762.1.4.1125.1).

Presence of an existing opioid and a new opioid or benzodiazepine prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2) and Medication, Discharge: Benzodiazepines (2.16.840.1.113762.1.4.1125.1) or Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2).

Presence of an existing benzodiazepine and a new opioid prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Benzodiazepines (2.16.840.1.113762.1.4.1125.1) and Medication, Discharge: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2).

Presence of an existing benzodiazepine and an existing opioid prescription at discharge resulting in concurrent therapy is represented by QDM datatypes and value sets of Medication, Active: Benzodiazepines (2.16.840.1.113762.1.4.1125.1) and Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2).

Presence of two or more existing opioids at discharge resulting in concurrent therapy is represented by QDM datatype and value set of Medication, Active: Schedule II and Schedule III Opioids (2.16.840.1.113762.1.4.1125.2).

To access the value sets for the measure, please visit the Value Set Authority Center (VSAC), sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)

The number of individuals from the denominator with:

- 2 or more prescription claims for any benzodiazepine with unique 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 prescriptions claims on unique 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 sum of the number of days (cumulative) during the measurement year with overlapping days’ supply for an opioid and a benzodiazepine. Exclude days of overlap that occur after the end of the measurement year.

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

Note: When identifying days’ supply for opioids (or benzodiazepines):
- Exclude any days’ supply that occur after the end of the measurement year.
- Multiple prescription claims with the same date of service: If multiple prescription claims for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days’ supply.

Table COB-B: Benzodiazepines:
Alprazolam, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, lorazepam, midazolam, oxazepam, quazepam, temazepam, triazolam (note: excludes injectable formulations)

Denominator Statement

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
The target population for this measure is individuals 18 years of age and older and prescribed long-term opioid therapy during the measurement year. Individuals are excluded if they have had any claims indicating a cancer diagnosis or hospice care at any time during the measurement year.

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Vulnerable adults who are given a prescription for an opioid

2940: Use of Opioids at High Dosage in Persons Without Cancer
Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

3316e: Safe Use of Opioids – Concurrent Prescribing
Patients age 18 years and older prescribed an opioid or a benzodiazepine at discharge from a hospital-based encounter (inpatient stay less than or equal to 120 days or emergency department encounters, including observation stays) during the measurement period.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
The denominator includes individuals 18 years and older with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days’ supply is 15 or more days. Individuals with cancer or in hospice are excluded.
**Denominator Details**

**3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)**

The measurement year is defined as 12 consecutive months. Continuous enrollment is defined as 11 out of 12 months enrollment in a health plan in the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year. Long-term opioid therapy is defined as at least 90 days of cumulative days’ supply of any combination of opioid medications indicated for pain during the measurement period identified using prescription claims. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation. The target population is adults enrolled in a Qualified Health Plan (QHP) and on long-term opioid therapy.

Eligible members for this measure are those members who:

1) Are 18 years of age and older as of the first day of the measurement year.
2) Are continuously enrolled in a QHP which is defined as at least 11 out of 12 months during the measurement year or enrolled with no gaps until the date of death.
3) Have pharmacy claims indicating at least 90 days of cumulative supply of any combination of opioid medications indicated for pain during the measurement year.

Opioid medications are specified in the attached Excel file “AMO_CompleteCoding_UPDATED” in the following sheets “2016_OPIOIDFORPAINMEDICATION,” “2017_OPIOIDFORPAINMEDICATION,” and “2018_OPIOIDFORPAINMEDICATION.”

Days’ supply is calculated by summing the days’ supply for every prescription during the measurement year for opioid medications indicated for pain from the above lists. Individuals qualify for the measure denominator if this sum is at least 90 days.

Note: The active ingredient of the opioid medications is limited to formulations indicated for pain and delivered through any route except intravenous (IV) or epidural (EP). These two routes are not included in this measure because they are not commonly prescribed as chronic pain medications. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.

**1617: Patients Treated with an Opioid who are Given a Bowel Regimen**

All vulnerable adults >17 years old prescribed an opioid as:

- An inpatient
- A hospice patient (inpatient or outpatient)
- A non-hospice outpatient in patients who are not already taking an opioid

"Vulnerable" is defined as any of the following:

- >74 years of age
- Vulnerable Elder Survey-13 (VES-13) score >2 (Saliba 2001)
- Poor prognosis/terminal illness defined as life expectancy of <6 months
- Stage IV cancer
- Patients receiving hospice care in any setting

2940: Use of Opioids at High Dosage in Persons Without Cancer
Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.
Table Opioid-A: Opioid Medications
buprenorphine butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.
Table Opioid-A: Opioid Medications
buprenorphine butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.
Table Opioid-A: Opioid Medications
buprenorphine butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol

3316e: Safe Use of Opioids – Concurrent Prescribing
Inpatient Encounters are represented using the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID: 2.16.840.1.113883.3.666.5.307). Length of stay is calculated within the measure based on encounter start and end dates. ED Encounters including observation stay are represented using the QDM datatype and value set of Encounter, Performed: Encounter ED and Observation Stay (OID: 2.16.840.1.113883.3.3157.1002.81).
Patients with an opioid or a benzodiazepine active on admission and continued at discharge are represented by the following QDM datatype and value sets:
- Medication, Active: Schedule II and Schedule III Opioids (OID: 2.16.840.1.113762.1.4.1125.2)
- Medication, Active: Benzodiazepines (OID: 2.16.840.1.113762.1.4.1125.1)
Patients who received a new opioid or benzodiazepine prescription at discharge from a qualifying encounter, not those patients who were given an opioid or benzodiazepine as part of their encounter treatment, are represented by the following QDM datatype and value sets:
- Medication, Discharge: Schedule II and Schedule III Opioids (OID: 2.16.840.1.113762.1.4.1125.2)
- Medication, Discharge: Benzodiazepines (OID: 2.16.840.1.113762.1.4.1125.1)
To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids with unique dates of service, for which the sum of the days’ supply is 15 or more days. 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 with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days’ supply is 15 or more days’ supply during the measurement year.
Step 4: Of those identified in step 3, 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)
Note: When identifying days’ supply for opioids:
• Exclude any days’ supply that occur after the end of the measurement year.
• Multiple prescription claims with the same date of service: If multiple prescription claims 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.
Table COB-A: Opioids:
buprenorphine, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol
(note: excludes injectable formulations; includes prescription opioid cough medications; excludes single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

Exclusions

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
The measure excludes individuals with: 1) a diagnosis of cancer at any time during the measurement year; or 2) hospice care at any time during the year.
1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Non-hospice outpatients who are already taking an opioid at the time of the study period opioid prescription

2940: Use of Opioids at High Dosage in Persons Without Cancer
Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016; (see list in S.11 and S.2b); or a hospice indicator from the enrollment database.

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Any member with a diagnosis for Cancer or a Prescription Drug Hierarchical Condition Category (RxHCC) 8, 9, 10, or 11 for Payment Year 2015; or RxHCC 15, 16, 17, 18, or 19 for Payment Year 2016 (see list in S.11 and S.2b); or a hospice indicator (Medicare Part D) from the enrollment database.

3316e: Safe Use of Opioids – Concurrent Prescribing
Denominator exclusions: The following encounters are excluded from the denominator:
- Encounters for patients with an active diagnosis of cancer during the encounter
- Encounters for patients who are ordered for palliative care during the encounter
- Inpatient encounters with length of stay greater than 120 days
Denominator exceptions: None.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.

Exclusion Details

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Members with a diagnosis of cancer are identified with the diagnosis codes listed below.
Cancer exclusion ICD-9 codes (for testing only):
- Include 140 through 239
- Omit 173.XX series
Cancer exclusion ICD-10 codes:
- Include C00 through D49
- Omit C44.XX series
Members with hospice care are identified with the codes listed below.
Hospice Codes 2015-2016:
- Revenue Codes – 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by May 14, 2020 by 6:00 PM ET.
CPT Codes – 99377, 99378
HCPCS Codes – G0182, G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q50005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T043, T2044, T2045, T2046

Note: A full list of codes is provided in the attached Excel file “AMO_CompleteCoding” in the sheet “Codes-2016 Data,” “Codes-2017 Data,” and “Codes-2018 Data.”

1617: Patients Treated with an Opioid who are Given a Bowel Regimen

Patients who are prescribed an opioid in the outpatient setting are excluded if they are NOT hospice patients AND at the time of the opioid prescription that occurred during the study period, they were already taking an opioid. This exclusion does NOT apply to inpatients or to hospice patients treated in any setting. Non-hospice outpatients who are prescribed an opioid who may have been on an opioid in the past, but are not taking an opioid at the time of the study period opioid prescription are NOT excluded.

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

Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice.

Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19

ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

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

Hospice Exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice.

Cancer Exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19

ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

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

Hospice exclusion: Exclude those members identified in the Medicare Enrollment Database as being enrolled in hospice.

Cancer exclusion: For Payment Year 2015: RxHCC 8, 9, 10, or 11. For Payment Year 2016: RxHCC 15, 16, 17, 18, or 19

ICD 9 and 10 Codes to Identify Cancer: Please see attachment in S2.b

3316e: Safe Use of Opioids – Concurrent Prescribing

Active cancer diagnosis or palliative care order during the encounter are represented using the QDM datatype and following value sets:
- Diagnosis: Cancer (2.16.840.1.113883.3.526.3.1010)
- Intervention, Performed: Palliative care (2.16.840.1.113762.1.4.1125.3)
- Intervention, Order: Palliative care (2.16.840.1.113762.1.4.1125.3)
3389: Concurrent Use of Opioids and Benzodiazepines (COB)
Hospice exclusion: Exclude any individual in hospice during the measurement year. To identify individuals in hospice:
• Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
• Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)
Cancer exclusion: Exclude any individuals with cancer during the measurement year. To identify individuals with cancer:
• Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
• For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html

Risk Adjustment

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
No risk adjustment or risk stratification
1617: Patients Treated with an Opioid who are Given a Bowel Regimen
No risk adjustment or risk stratification
2940: Use of Opioids at High Dosage in Persons Without Cancer
No risk adjustment or risk stratification
2950: Use of Opioids from Multiple Providers in Persons Without Cancer
No risk adjustment or risk stratification
2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
No risk adjustment or risk stratification
3316e: Safe Use of Opioids – Concurrent Prescribing
No risk adjustment or risk stratification
3389: Concurrent Use of Opioids and Benzodiazepines (COB)
No risk adjustment or risk stratification

Stratification

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Not applicable.
1617: Patients Treated with an Opioid who are Given a Bowel Regimen

2940: Use of Opioids at High Dosage in Persons Without Cancer
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 status
Definition: Medicare Low Income Subsidy (LIS) - A subsidy paid by the Fed

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
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 status
Definition: Medicare Low Income Subsidy (LIS)
A subsidy paid by the Fed

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
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 status
Definition: Medicare Low Income Subsidy (LIS)
A subsidy paid by the Fed

3316e: Safe Use of Opioids – Concurrent Prescribing
Not applicable; this measure is not stratified.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)
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 pla

Type Score

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Rate/proportion better quality = lower score

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
Rate/proportion better quality = higher score
2940: Use of Opioids at High Dosage in Persons Without Cancer  
Rate/proportion better quality = lower score

2950: Use of Opioids from Multiple Providers in Persons Without Cancer  
Rate/proportion better quality = lower score

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer  
Rate/proportion better quality = lower score

3316e: Safe Use of Opioids – Concurrent Prescribing  
Rate/proportion better quality = lower score

3389: Concurrent Use of Opioids and Benzodiazepines (COB)  
Rate/proportion better quality = lower score

Algorithm

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)  
Denominator: Individuals 18 years of age and older who are on long-term opioid therapy during the measurement year.

Create Denominator:
1. Include all individuals enrolled in a health plan for 11 of 12 months during the measurement year or enrolled with no gaps in enrollment until the month of death in the measurement year.
   a. For QHPs in the Health Insurance Marketplace, switching between QHP products is considered continuous enrollment if enrollment and claims/encounter data are available for 11 of 12 months. The measure score is attributed to the last enrolled QHP product, in accordance with technical guidance specific to the Health Insurance Marketplace Quality Rating System (QRS), available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Revised_QRS-2018-Measure-Tech-Specs_20170929_S08.pdf.
2. Include individuals from step 1 who were 18 years of age or older as of the first day of the measurement year.
3. Include individuals from step 2 with a total days’ supply of opioids of 90 days or more identified in pharmacy claims (section S.7).
4. Exclude individuals with any institutional or non-institutional claims indicating a cancer diagnosis during the measurement year (section S.9)
5. Exclude individuals with any institutional or non-institutional claims indicating hospice care during the measurement year (section S.9)
6. Include only unique members from step 5 in the final denominator.

Numerator: Individuals in the denominator population with no claims for drug tests during the measurement year.

Create Numerator:
7. Include individuals from the denominator who do not have any claims for a drug test during the measurement year (section S.5)

Calculate Measure Score:
8. The measure score is calculated as the number of individuals in the numerator divided by the number of individuals in the denominator multiplied by 100 (to produce a percentage).

For the Health Insurance Marketplace, members are attributed to the last QHP enrolled product during the measurement year.

**1617: Patients Treated with an Opioid who are Given a Bowel Regimen**

Note that edits placed in brackets [ ]

1. Identify vulnerable adults with a prescription for an opioid. For inpatients, identify ALL patients with an order for [standing (not prn)] opioid treatment on admission or during the hospitalization. For hospice patients, identify ALL patients with an order for opioid treatment on admission or during the episode of hospice care. For outpatient non-hospice patients, identify patients with a "new" prescription for an opioid. "New" prescription for a non-hospice outpatient means that the patient is not already taking an opioid.

2. Include only patients who are vulnerable (age >74, VES-13 score >2, or poor prognosis/terminally ill, advanced cancer, patients receiving hospice care).

3. Look for documentation within 24 hours of opioid prescription for a prescription for a laxative, stool softener, or high fiber supplement/diet OR documentation as to why such a regimen was not needed.

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

Step One:
Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Step Two:
Calculate the numerator by:
For each member in the denominator:

a. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:
   - # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)
   - MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)

b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.

c. Identify the days where the MED threshold is exceeded.

d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Step Three:
Divide the number of members that met the criteria in numerator (Step Two d.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

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

Step One:
Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Step Two:
Calculate the numerator by:
   a. Calculate the number of unique pharmacy providers associated with an opioid prescription claim.
   b. Calculate the number of unique prescribers associated with an opioid prescription claim.
   c. Any member with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

Step Three:
Divide the number of members that met the criteria in numerator (Step Two c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

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

Step One:
Calculate the denominator by identifying the number of all eligible members with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15.

Step Two:
Calculate the numerator by:
   For each member in the denominator:
   a. Calculate the MED for each opioid prescription claim during the measurement period, using the following equations:
      • # of Opioid Dosage Units per day = (Opioid claim quantity) / (Opioid claim days supply)
      • MED Daily Dose per claim = (# of opioid dosage units per day) X (# mg opioid per dosage unit) X (MED conversion factor)
   b. Sum the daily MEDs of all opioid claims for each day to arrive at a total daily MED for each member.
   c. Identify the days where the MED threshold is exceeded.
   d. Any member, for whom the MED threshold is exceeded for 90 consecutive days or longer, meets the criteria for the MED component of the numerator.

Step Three: From those members meeting the MED component in (Step 2d.) identify those members who received opioids from 4 or more prescribers AND 4 or more pharmacies.
   a. Calculate the number of unique pharmacy providers associated with an opioid prescription claim.
   b. Calculate the number of unique prescribers associated with an opioid prescription claim.
   c. Any member from Step 2d with four or more unique pharmacy providers AND four or more unique prescribers meets the criteria for the Numerator.

Step Four:
Divide the number of members that met the criteria in numerator (Step Three c.) by the denominator (Step One) and multiply times 1000. The rate is reported as a proportion: XX out of 1,000 members.

3316: Safe Use of Opioids – Concurrent Prescribing
Please see the attached HQMF specifications for the complete measure logic. Additionally, a flow diagram of the denominator and numerator logic is attached to the NQF submission form as a supplemental document in response to question A.1, ‘Opioids_LogicFlow_for S.14 response.pdf’.

3389: Concurrent Use of Opioids and Benzodiazepines (COB)

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 with 2 or more prescription claims for opioids on unique dates of service, for which the sum of the days’ supply is 15 or more days’ supply during the measurement year.
Step 4: Of those identified in step 3, 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)
Note: When identifying days’ supply for opioids:
• Exclude any days’ supply that occur after the end of the measurement year.
• Multiple prescription claims with the same date of service: If multiple prescription claims 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.
Step 5: Identify individuals with cancer or in hospice during the measurement year.
To identify individuals in hospice:
• Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or
• Use place of service code 34 where a hospice indicator is not available (e.g. Commercial, Medicaid)
To identify individuals with cancer:
• Using ICD codes, refer to those listed in the file titled, PQA ICD Code Cancer Value Set Feb 2018 and attached in S.2b. The list is based on the American Medical Association-convened Physician Consortium for Performance Improvement Cancer value set (OID: 2.16.840.1.113883.3.526.3.1010). A cancer diagnosis is defined as having at least one claim with any of the listed cancer diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year.
For Medicare Data, if ICD codes are not available, use Prescription Drug Hierarchical Condition Categories (RxHCCs) 15, 16, 17, 18, 19 for Payment Year 2016 or 2017 to identify cancer exclusions. RxHCCs are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Risk-Adjustors.html

Step 6: Exclude individuals with cancer or in hospice (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 on unique 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 opioid and benzodiazepine prescriptions during the measurement year.

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

Note: When identifying days’ supply for opioids (or benzodiazepines):

- Exclude any days’ supply that occur after the end of the measurement year.
- Multiple prescription opioid (or benzodiazepine) claims with overlap: For multiple prescription claims for opioids (or benzodiazepines) with overlapping days’ supply, count each day in the measurement year only once toward the denominator. There is no adjustment for early fills or overlapping days’ supply for opioids (or benzodiazepines).

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.

Submission items

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

5.1 Identified measures: 1617: Patients Treated with an Opioid who are Given a Bowel Regimen
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
3316: Safe Use of Opioids – Concurrent Prescribing
3389: Concurrent Use of Opioids and Benzodiazepines (COB)

5a.1 Are specs completely harmonized? Yes
5a.2 If not completely harmonized, identify difference, rationale, impact: An environmental scan revealed related measures listed above, which share similar populations of interest (patients receiving opioids). NQF 1617 targets vulnerable adults given a new prescription for an opioid, and therefore has a different target population than the AMO measure. NQF 3316e is an eCQM that targets patients discharged from a hospital-based encounter, a different setting of care than the AMO measure. Harmonization of value sets has been addressed to the extent possible with related outpatient health plan measures, NQF 2940, 2950, 2951, and 3389, including the cancer and hospice exclusions and targeted opioid medications. The AMO measure’s area of focus (numerator) does not overlap with any existing measure, and its focus on drug tests for patients on long-term opioid therapy is unique. Therefore, while there are some related measures that evaluate similar target populations of patients receiving opioid therapy, the AMO measure is a new and evidence-based focus to empower health plans to address opioid misuse and opioid use disorder, and improve patient safety. Harmonization has been addressed to the extent possible, and PQA will continue to identify and address opportunities to harmonize with related measures over time.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

1617: Patients Treated with an Opioid who are Given a Bowel Regimen
5.1 Identified measures:
5a.1 Are specs completely harmonized?
5a.2 If not completely harmonized, identify difference, rationale, impact:
5b.1 If competing, why superior or rationale for additive value: This measure was part of the National Palliative Care Research Center (NPCRC) Key Palliative Measures Bundle during the original submission. At that time, a NPCRC cover letter and table of bundle measures for description of the selection and harmonization of the Key Palliative Measures Bundle was provided.

2940: Use of Opioids at High Dosage in Persons Without Cancer
5.1 Identified measures:
5a.1 Are specs completely harmonized?
5a.2 If not completely harmonized, identify difference, rationale, impact:
5b.1 If competing, why superior or rationale for additive value: N/A

2950: Use of Opioids from Multiple Providers in Persons Without Cancer
5.1 Identified measures:
5a.1 Are specs completely harmonized?
5a.2 If not completely harmonized, identify difference, rationale, impact:
5b.1 If competing, why superior or rationale for additive value: N/A

2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
5.1 Identified measures:
5a.1 Are specs completely harmonized?
5a.2 If not completely harmonized, identify difference, rationale, impact:
5b.1 If competing, why superior or rationale for additive value: N/A
3316: Safe Use of Opioids – Concurrent Prescribing

5.1 Identified 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

5a.1 Are specs completely harmonized? Yes
5a.2 If not completely harmonized, identify difference, rationale, impact: This proposed measure is a new measure. The list of Schedule II and III opioids and denominator exclusions are harmonized, where feasible, with NQF-endorsed PQA measures 2940, 2950, and 2951. The measure specifications of the proposed measure are not completely harmonized with these PQA measures as they do not include benzodiazepines in the measure focus. Below we describe the differences between the proposed measure and NQF #2940, #2950, and #2951: The eligible population for the Concurrent Prescribing measure captures not only patients prescribed at least one opioid at discharge, but also patients prescribed at least one benzodiazepine at discharge per the measure focus. Experts stressed the importance of including both opioids and benzodiazepines in the denominator to ensure that the measure takes into consideration any iatrogenic risk from co-prescribing for both populations already on opioids or benzodiazepines; Only Schedule II and Schedule III opioids are in scope of the Concurrent Prescribing measure per expert consensus. The PQA measures also include Schedule IV opioids; The Concurrent Prescribing measure assesses patients across the hospital inpatients and outpatient settings (ED, including observation stays) per the programs in which the measure will be proposed for implementation. The PQA measure focuses on the prescription drug health plan level.

5b.1 If competing, why superior or rationale for additive value: Not applicable

3389: Concurrent Use of Opioids and Benzodiazepines (COB)

5.1 Identified 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

5a.1 Are specs completely harmonized? Yes
5a.2 If not completely harmonized, identify difference, rationale, impact: 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.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that addresses both the same measure focus and the same target population).
Behavioral Health and Substance Use, Fall 2019 Cycle: CDP Report Comparison of NQF #3539e and NQF #2993

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
2993: Potentially Harmful Drug-Disease Interactions in the Elderly

Steward

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
   Centers for Medicare & Medicare Services

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
   National Committee for Quality Assurance

Description

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
   Proportion of inpatient hospitalizations for patients 65 years of age and older who receive
   an order for antipsychotic medication therapy.

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
   The percentage of patients 65 years of age and older who have evidence of an underlying
disease, condition or health concern and who are dispensed an ambulatory prescription for
a potentially harmful medication, concurrent with or after the diagnosis. Four rates are
reported for this measure:
   -Rate 1: The percentage of those with a history of falls that received a potentially
     harmful medication
   -Rate 2: The percentage of those with dementia that received a potentially harmful
     medication
   -Rate 3: The percentage of those with chronic kidney disease that received a potentially
     harmful medication
   -Rate 4: Total rate
   A lower rate represents better performance for all rates.

Type

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
   Process

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
   Process

Data Source

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
   Electronic Health Records Hospitals collect EHR data using certified electronic health
   record technology (CEHRT). The human readable format and XML are contained in the
eCQM specifications attached in question S.2a. No additional tools are used for data
   collection for eMeasures.
   No data collection instrument provided Attachment AP_value_sets_codes.xlsx
**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**

Claims, Electronic Health Data, Electronic Health Records This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA’s online data submission system.

No data collection instrument provided Attachment DDE_Value_Sets-635979522717911582.xlsx

**Level**

**3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**
Facility

**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**
Health Plan, Integrated Delivery System

**Setting**

**3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**
Inpatient/Hospital

**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**
Outpatient Services

**Numerator Statement**

**3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**
Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.

**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**
Numerator 1: Patients with a history of falls who received at least one potentially harmful medication from Table DDE-A or Table DDE-B
Numerator 2: Patients with a diagnosis of dementia who received at least one potentially harmful medication from Table DDE-D
Numerator 3: Patients with chronic kidney disease who received at least one potentially harmful medication from Table DDE-E
Numerator 4: The sum of the three numerators

**Numerator Details**

**3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**
The time period for data collection is the measurement year (12-month period). Numerator: Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.
Antipsychotic orders are represented with the QDM datatype and value set of Medication, Order: Antipsychotic Medications (OID:2.16.840.1.113883.3.464.1003.196.12.1255).
Numerator exclusions: Inpatient hospitalizations for patients with documented indication that they are threatening harm to self or others.
Threat to self or others is represented with the QDM datatype and value set of Symptom: Threat to themselves or others (OID:2.16.840.1.113883.3.464.1003.195.12.1020).

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**

Rate 1 numerator: Dispensed an ambulatory prescription for an anticonvulsant, nonbenzodiazepine hypnotic, or SSRI (Table DDE-A), antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B) on or between the index episode start data and December 31 of the measurement year.

Rate 2 numerator: Dispensed an ambulatory prescription for an antipsychotic, benzodiazepine, nonbenzodiazepine hypnotic or tricyclic antidepressant (Table DDE-B), or H2 receptor antagonist or anticholinergic agent (Table DDE-D) on or between the IESD and December 31 of the measurement year.

Rate 3 numerator: Dispensed an ambulatory prescription for an NSAID or Cox-2 selective NSAID (Table DDE-E) on or between the IESD and December 31 of the measurement year.

Rate 4 numerator: The sum of numerators 1, 2 and 3.

Note: Do not include denied claims.

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Table DDE-A: Potentially Harmful Drugs – Rate 1

Anticonvulsants:
- Carbamazepine, Clobazam, Divalproex sodium, Ethosuximide, Ethotoin, Ezogabine, Felbamate, Fosphenytoin, Gabapentin, Lacosamide, Lamotrigine, Levetiracetam, Mephobarbital, Methsuximide, Oxcarbazepine, Phenobarbital, Phenytoin, Pregabalin, Primidone, Rufinamide, Tiagabine HCL, Topiramate, Valproate sodium, Valproic acid, Vigabatrin, Zonisamide

SSRIs:
- Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

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Table DDE-B: Potentially Harmful Drugs – Rate 1 (History of Falls) and Rate 2 (Dementia)

Antipsychotics:
- Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Perphenazine, Pimozide, Quetiapine, Risperidone, Thioridazine, Thiothixene, Trifluoperazine, Ziprasidone

Benzodiazepine hypnotics:
- Alprazolam, Chlordiazepoxide products, Clonazepam, Clorazepate-Dipotassium, Diazepam, Estazolam, Flurazepam HCL, Lorazepam, Midazolam HCL, Oxazepam, Quazepam, Temazepam, Triazolam

Nonbenzodiazepine hypnotics:
- Eszopiclone, Zaleplon, Zolpidem

Tricyclic antidepressants:
Amitriptyline, Amoxapine, Clomipramine, Desipramine, Doxepin (>6 mg), Imipramine, Nortriptyline, Protriptyline, Trimipramine
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Table DDE-D: Potentially Harmful Drugs – Rate 2 (Dementia)
H2 receptor antagonists:
Cimetidine, Famotidine, Nizatidine, Ranitidine
Anticholinergic agents, antiemetics:
Prochlorperazine, Promethazine
Anticholinergic agents, antihistamines:
Carbinoxamine, Chlorpheniramine, Hydroxyzine products, Brompheniramine, Clemastine, Cyproheptadine, Promethazine, Tripolidine, Dimenhydrinate, Diphenhydramine, Meclizine, Dextromethorphan, Dextropropoxyphene, Doxylamine
Anticholinergic Agents, antimuscarinics (oral)
Atropine, Homatropine, Belladonna alkaloids, Dicyclomine, Hyoscyamine, Propantheline, Scopolamine, Clidinium-chlordiazepoxide
Anticholinergic agents, antimuscarinics (oral)
Darifenacin, Fesoterodine, Solifenacin, Trosipium, Flavoxate, Oxybutynin, Tolterodine
Anticholinergic agents, anti-Parkinson agents
Benztropine, Trihexyphenidyl
Anticholinergic agents, skeletal muscle relaxants
Cyclobenzaprine, Orphenadrine
Anticholinergic agents, SSRIs:
Paroxetine
Anticholinergic agents, antiarrhythmic:
Disopyramide
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Table DDE-E: Cox-2 Selective NSAIDs and Nonaspirin NSAIDs
Cox-2 Selective NSAIDs:
Celecoxib
Nonaspirin NSAIDs:
Diclofenac potassium, Diclofenac sodium, Etodolac, Fenoprofen, Flurbiprofen, Ibuprofen, Indomethacin, Ketoprofen, Ketorolac, Meclofenamate, Mefenamic acid, Meloxicam, Nabumetone, Naproxen, Naproxen sodium, Oxaprozin, Piroxicam, Sulindac, Tolmetin

Denominator Statement

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
Non-psychiatric inpatient hospitalizations for patients who are 65 and older.

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
All patients ages 65 years of age and older with a history of falls, dementia or chronic kidney disease in the measurement year or the year prior to the measurement year.
**Denominator Details**

**3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting**

The time period for data collection is the measurement year (12-month period).

Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older. Inpatient hospitalizations are represented with the QDM datatype and value set of Encounter, Performed: Encounter Inpatient (OID:2.16.840.1.113883.3.666.5.3001).

To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

**2993: Potentially Harmful Drug-Disease Interactions in the Elderly**

All patients ages 67 years and older as of December 31 of the measurement year with a history of falls, dementia or chronic kidney disease. Each of the four rates in the measure has a different denominator:

Rate 1 denominator: Patients with an accidental fall or hip fracture (Note: hip fractures are used as a proxy for identifying accidental falls). Individuals with either of the following on or between January 1 of the year prior to the measurement year and December 1 of the measurement year meet criteria:

- An accidental fall (Falls Value Set).
- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set), with a hip fracture (Hip Fractures Value Set).
- An acute or nonacute inpatient discharge with a hip fracture (Hip Fractures Value Set). To identify acute and nonacute inpatient stays (Inpatient Stay Value Set). 2) Identify the discharge date for the stay.

Rate 2 denominator: Patients with a diagnosis of dementia (Dementia Value Set) or a dispensed dementia medication (Table DDE-C) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Rate 3 denominator: Patients with chronic kidney disease as identified by a diagnosis of ESRD (ESRD Value Set), stage 4 chronic kidney disease (CKD Stage 4 Value Set) or kidney transplant (Kidney Transplant Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Rate 4 denominator: The sum of the denominators for rates 1, 2 and 3

Note: Patients with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify).

See S.2.b for all Value Sets

Table DDE-C: Prescriptions to Identify Members with Dementia

Cholinesterase inhibitors:

Donepezil, Galantamine, Rivastigmine

Miscellaneous central nervous system agents:

Memantine
Exclusions

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.
Inpatient hospitalizations for patients who were taking antipsychotics prior to admission.

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
The following are exclusions for the condition-specific rates and total rate:
For those who meet denominator criteria for the history of falls rate (Rate 1): exclude those with a diagnosis of psychosis, schizophrenia, bipolar disorder or seizure disorder.
For those who meet denominator criteria for those with dementia rate (Rate 2): exclude those with a diagnosis of psychosis, schizophrenia or bipolar disorder.

Exclusion Details

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
The following data elements are used to define the measure exclusions:
Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter. These exclusions are represented with the QDM datatype of Diagnosis.
Schizophrenia or Psychotic Disorder (OID: 2.16.840.1.113883.3.464.1003.105.12.1104)
Tourette's Syndrome (OID: 2.16.840.1.113883.3.464.1003.105.12.1030)
Bipolar Disorder (OID: 2.16.840.1.113883.3.67.1.101.1.128)
Huntington's Disease (OID: 2.16.840.1.113883.3.464.1003.105.12.1032)
Denominator Exclusions: Inpatient hospitalizations for patients who were taking antipsychotics prior to admission.
Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255)
This exclusion is represented with the QDM datatype of Medication, Active:
Antipsychotic Medications (OID: 2.16.840.1.113883.3.464.1003.196.12.1255)
To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
For those who meet denominator criteria for the history of falls rate (Rate 1): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set), bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) or seizure disorder (Seizure Disorders Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.
For those who meet denominator criteria for those with dementia rate (Rate 2): Exclude patients with a diagnosis of psychosis (Psychosis Value Set), schizophrenia (Schizophrenia Value Set) or bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year.
See S.2.b for all Value Sets
Risk Adjustment

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
Stratification by risk category/subgroup

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
No risk adjustment or risk stratification

Stratification

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
Results include a total score and the following strata:
Stratum 1 - Patients who were admitted or transferred to the ICU during the inpatient encounter
Stratum 2 - Patients who were not admitted or transferred to the ICU during the inpatient encounter
These strata are identified using the QDM datatype of Encounter, Performed.
ICU Admission or Transfer (OID: 2.16.840.1.113883.17.4077.3.2040)
To access the value sets for the measure, please visit the Value Set Authority Center, sponsored by the National Library of Medicine, at https://vsac.nlm.nih.gov/. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
No risk adjustment or risk stratification

Type Score

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
Rate/proportion better quality = lower score

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
Rate/proportion better quality = lower score

Algorithm

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
See '1a._AP_Logic_Flow.pdf' submitted as an attachment under S.2a above.

2993: Potentially Harmful Drug-Disease Interactions in the Elderly
Step 1. Determine the eligible population: All patients 67 years of age and older as of the end (i.e., December 31) of the measurement year.
Step 2: Identify the denominators for each of the four rates:
Rate 1: Those in the eligible population with a history of falls (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia, bipolar disorder, or seizure disorder (see S.11 for details). Identify the index episode start date.
Rate 2: Those in the eligible population with a dementia (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Exclude patients with a diagnosis of psychosis, schizophrenia or bipolar disorder (see S.11 for details). Identify the index episode start date.
Rate 3: Those in the eligible population with end stage renal disease (see S.9 for details) on or between January 1 of the year prior to the measurement year and December 1 of the measurement year. Identify the index episode start date.

Rate 4: The sum of denominators for Rates 1, 2 and 3.

Step 3: Identify the numerators: Individuals in each of the denominators who have received at least one potentially harmful medication on or after the index episode start date (see definitions of potentially harmful medications for each numerator in section S.6).

Step 4: Calculate the rates:
Rate 1 – Numerator 1 divided by denominator 1.
Rate 2 – Numerator 2 divided by denominator 2.
Rate 3 – Numerator 3 divided by denominator 3.
Rate 4 – The sum of the three numerators divided by the sum of the three denominators.

Note: for this measure a lower rate indicates better performance for all four rates.

Index Episode Start Date. The earliest diagnosis, procedure or prescription between January 1 of the year prior to the measurement year and December 1 of the measurement year.

For an outpatient claim/encounter, the IESD is the date of service.
For an inpatient claim/encounter, the IESD is the discharge date.
For dispensed prescriptions, the IESD is the dispense date.

Submission items

3539e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

5.1 Identified measures:
5a.1 Are specs completely harmonized? Yes
5a.2 If not completely harmonized, identify difference, rationale, impact: These measures are harmonized to the extent possible. While all measures assess the potentially inappropriate use of antipsychotic medications, this is the only measure that assesses use of antipsychotic medications in the inpatient hospital setting. CMS N011.01 and CMS N031.02 are intended for use in the nursing home setting. Measures NQF 2111 and NQF 2993 assess health plan performance. This measure’s eligible population includes all patients in an inpatient hospital setting who are age 65 and older, which aligns with the age for measures NQF 2111 and NQF 2993. NQF 2111 and NFQ 2993 only assess older adults with dementia, whereas this measure includes all older adults. The denominator exclusions are similar across measures. The exclusions in this measure—schizophrenia (including psychotic disorders), Tourette’s syndrome, Huntington’s disease, and bipolar disorder—are similar to exclusions in related measures. CMS N011.01, CMS N031.02, and NQF 2111 exclude patients with schizophrenia, Tourette’s syndrome, or Huntington’s disease. NQF 2111 also excludes patients with bipolar disorder. NQF 2993 excludes patients with psychosis, schizophrenia, or bipolar disorder. This measure also excludes from the numerator people in the inpatient setting who are identified as a threat to themselves or others. No other measure excludes these patients, although this exclusion is appropriate for the hospital setting. The specific antipsychotic medications included in each measure are aligned.
5b.1 If competing, why superior or rationale for additive value: Not applicable.
2993: Potentially Harmful Drug-Disease Interactions in the Elderly

5.1 Identified measures: 0022: Use of High-Risk Medications in the Elderly (DAE)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure and NQF 0022 have a similar focus (measuring potentially inappropriate medication use in the elderly) and reporting level (health plan), however they have different target populations. This measure targets patients with a specific condition or disease that can experience adverse effects when combined with certain medications that are recommended to be avoided for that condition. NQF 0022 targets a larger population of all older adults and assesses use of high-risk medications that have been recommended to be avoided in all older adults.

5b.1 If competing, why superior or rationale for additive value: N/A
Appendix F: Pre-Evaluation Comments

Comments received as of January 21, 2020.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Commenter</th>
<th>Comment</th>
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<tbody>
<tr>
<td>3492: Acute Care Use Due to Opioid Overdose</td>
<td>Submitted by Academic Pediatric Association</td>
<td>I support the adoption of this measure.</td>
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</tbody>
</table>
| 3492: Acute Care Use Due to Opioid Overdose | Submitted by Joshua Sharfstein | I support the adoption of this measure for several reasons:  
* Nonfatal overdose is a serious event that is highly predictive of fatal overdose  
* Population-based measures (meaning a geographic population) reflect community health.  
* There are important steps that the clinical community can take to reduce the risk of nonfatal overdose in a geographic population, such as improve access to medications for opioid use disorder, which are associated with declines in death rates of 50% or more.  

Other related measures could include fatal overdoses in a geographic population. |
| 3492: Acute Care Use Due to Opioid Overdose | Submitted by Geoff Dougherty, PhD, MPH | The proposed measure has a clearly and appropriately defined numerator and denominator. The rate of ED visits due to opioid overdose events is an important indicator of prevalence and severity of opioid use disorder in a given geographic area, and thus can provide useful guidance to officials working to identify public health priorities, allocate public-health and clinical resources, and gauge the effectiveness of interventions targeting opioid use. For these reasons, I support the measure as submitted.  

Thanks for your consideration. |