NATIONAL QUALITY FORUM
Driving measurable health improvements together

Memo

July 28, 2020

To: Consensus Standards Approval Committee (CSAC)

From: Behavioral Health and Substance Use Project Team

Re: Behavioral Health and Substance Use Fall 2019, Track 1 Measures

COVID-19 Updates

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

> **Track 1: Measures Continuing in Fall 2019 Cycle**
> **Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations will be reviewed by the CSAC.**
>
> o **Exceptions**
>   Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.
>
> **Track 2: Measures Deferred to Spring 2020 Cycle**
> **Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle.** This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time. Track 2 measures will be reviewed during the CSAC's meeting in November.

During the CSAC meeting on July 28-29, the CSAC will review Fall 2019 measures assigned to Track 1. Evaluation summaries for measures in Track 1 have been described in this memo and related Behavioral Health and Substance Use draft report. A list of measures assigned to Track 2 can be found in the Executive Summary section of the Behavioral Health and Substance Use draft report for tracking purposes and will be described further in a subsequent report. Measures in track 2 will be reviewed by the CSAC on November 17-18, 2020.

CSAC Action Required

The CSAC will review recommendations from the Behavioral Health and Substance Use, Track 1 project at its July 28-29, 2020 meeting and vote on whether to uphold the recommendations from the

http://www.qualityforum.org

Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. Behavioral Health and Substance Use, Track 1 Draft Report. The draft report includes measure evaluation details on all measures that followed Track 1. Measures that followed Track 2 will be reviewed during the CSAC's meeting in November. The complete draft report and supplemental materials are available on the project webpage.
2. Comment Table. This table lists comments received during the post-meeting comment period. One of these comments relates to Track 1 measures and the other comments in the table relate to Track 2 measures.

Background

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.

This project sought to identify and endorse performance measures for accountability and quality improvement that address conditions, treatments, interventions, or procedures relating to behavioral health and substance use.

Draft Report

The Behavioral Health and Substance Use Fall 2019, Track 1 draft report presents the results of the evaluation of three measures considered under the Consensus Development Process (CDP). All three are recommended for endorsement.

The measures were evaluated against the 2019 version of the NQF measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	2	1	3
Measures recommended for endorsement	2	1	3

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of three candidate consensus

measures.

Measures Recommended for Endorsement

- NQF 2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics (NCQA)

Overall Suitability for Endorsement: Yes-15; No-0

- NQF 2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (NCQA)

Overall Suitability for Endorsement: Yes-15; No-0

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

Overall Suitability for Endorsement: Yes-18; No-0

Comments and Their Disposition

NQF received one comment from one member organization pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the NQF responses to each comment, is posted to the Behavioral Health and Substance Use project webpage.

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expression of support. Appendix C details the expressions of support or non-support.

Removal of NQF Endorsement

Six measures previously endorsed by NQF have not been re-submitted, and endorsement has been removed.

Measure	Measure Description	Reason for Removal of Endorsement
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA	Measure has not been implemented in programs; developer has no performance data to support maintenance endorsement
2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA	Measure has not been implemented in programs; developer has no performance data to support maintenance endorsement
2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	NCQA	Measure has not been implemented in programs; developer has no performance data to support maintenance endorsement

Measure	Measure Description	Reason for Removal of Endorsement
2602 Controlling High Blood Pressure for People with Serious Mental Illness	NCQA	Measure has not been implemented in programs; developer has no performance data to support maintenance endorsement
2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	NCQA	Measure has not been implemented in programs; developer has no performance data to support maintenance endorsement
2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	NCQA	Measure has not been implemented in programs; developer has no performance data to support maintenance endorsement

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	Yes	
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Measures Not Recommended for Endorsement

Not applicable.

Appendix C: NQF Member Expression of Support Results

No NQF members provided an expression of support.

Appendix D: Details of Measure Evaluation

Measures Recommended

2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics
<u>Submission</u> **|** <u>Specifications</u>

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:

Reliability:

- Overall reliability (mean) statistics were 0.875 for commercial plans and 0.985 for Medicaid plans.

2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics

- 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; 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-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

No public or member comments were received.

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

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.
- The Committee noted that commercial plan reliability scores below 25th percentile were below 0.61.

2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
• 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; 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-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   No public or member comments were received.
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 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.   **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.   **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**

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

(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.
    - 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).
    - 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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).
    - 52 of 62 Medicare Prescription Drug Plans (PDPs) had at least 100 beneficiaries in the denominator.
    - 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.
    - 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 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

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.

3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
7. Public and Member Comment
No public or member comments were received.
8. Consensus Standards Approval Committee (CSAC) Vote:
9. Appeals

Standing Committee Recommendations

- Seven measures reviewed for Fall 2019
  - Two measures reviewed by the Scientific Methods Panel

- Three measures recommended for endorsement
  - 2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics
  - 2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
  - 3541 Annual Monitoring for Persons on Long-Term Opioid Therapy

- Three measures deferred to Spring 2020 due to COVID-19 extended commenting periods
  - 3175 Continuity of Pharmacotherapy for Opioid Use Disorder and NQF
  - 3538 All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care
  - 3539e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

- One measure withdrawn prior to the post-commenting period
  - 3492 Acute Care Use Due to Opioid Overdose

Overarching Issues

- Interpretation of Year-Over-Year Improvement Data
  - On reviewing criteria related to Usability and Use, the Committee noted that several of the measures did not exhibit significant improvements in year-over-year performance.
  - Committee members noted that this was difficult to interpret.
  - 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.

Overarching Issues

- Measure Validity Beyond the Tested Population
  - 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.
  - There is a potential need to risk-adjust or stratify measure results at a population level in order to perform appropriate comparisons between state-level performances.

Public and Member Comment and Member Expressions of Support

- One comment received was supportive of measure 3541.

- No NQF member expressed support or concern for the measures.

Timeline and Next Steps

Process Step	Timeline
CSAC Endorsement Meeting	July 28 - 29, 2020
Appeals Period	August 3 - September 1, 2020

Questions?

- Project team:
  - Samuel Stolpe, Senior Director
  - Tamara Funk, Manager
  - Udobi Onyeuku, Analyst
  - Mike DiVecchia, Project Manager

- Project webpage:
  http://www.qualityforum.org/behavioral_health_and_substance_use.aspx

- Project email address: behavioralhealth@qualityforum.org

THANK YOU.

NATIONAL QUALITY FORUM

http://www.qualityforum.org

NATIONAL QUALITY FORUM
Driving measurable health
improvements together

Behavioral Health and Substance Use, Fall 2019 Cycle Track 1: CDP Report

DRAFT REPORT FOR CSAC REVIEW
JULY 28-29, 2020

http://www.qualityforum.org

Contents

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.[1] 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.

Due to circumstances around the COVID-19 global pandemic, commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered into one of two tracks:

Track 1: measures continuing its review in Fall 2019 Cycle:

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

Track 2: measures deferred to Spring 2020 Cycle:

- **NQF 3538** All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care
- **NQF 3175** Continuity of Pharmacotherapy for Opioid Use Disorder
- **NQF 3539e** Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

Measure Withdrawn

- **NQF 3492** Acute Care Use Due to Opioid Overdose

This report contains details of the evaluation of measures assigned to *Track 1* and are continuing in the Fall 2019 cycle. The detailed evaluation summary of measures assigned to *Track 2* and deferred to the Spring 2020 cycle will be included in a subsequent report. Brief summaries of the Fall 2019 *Track 1* measures currently under review 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. The measure listed as withdrawn was discussed and voted on by the Committee during the Fall 2019 measure evaluation meetings and was included in the draft report post for public comment, but was subsequently withdrawn by the developer prior to an endorsement discussion and vote by CSAC.

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

	Process	Outcome/Resource Use	Composite
Alcohol and Drug Use	4	0	1
Care Coordination	2	0	0
Depression	5	4	0
Medication Use	10	0	0
Experience of Care	2	0	0
Tobacco	4	0	0
Physical Health	8	2	0
Total	35	6	1

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. Three measures were assigned to *Track 1* and are continuing in the Fall 2019 cycle. The detailed evaluation summary of the three measures assigned to *Track 2* and deferred to the Spring 2020 cycles will be included in a subsequent report. One measure was withdrawn prior to the post-commenting period and will not be reviewed for endorsement.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary- Track 1

	Maintenance	New	Total
Measures under consideration	2	1	3
Measures recommended for endorsement	2	1	3

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. 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.

Comments Received After Committee Evaluation

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

> **Track 1: Measures Continuing in Fall 2019 Cycle**
> **Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations** will move forward to the CSAC for review and discussion during its meeting on July 28-29.
>
> o **Exceptions**
>   Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.
>
> **Track 2: Measures Deferred to Spring 2020 Cycle**
> **Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle.** This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time.

During the Fall 2019 CSAC meeting on July 28-29, the Consensus Standards Approval Committee (CSAC) will review all measures assigned to Track 1. A list of measures assigned to Track 2 can be found in the Executive Summary section of this report for tracking purposes, but these measures will be reviewed by CSAC on November 17 and 18, 2020.

The extended public commenting period with NQF member support closed on May 14, 2020. Following the Committee's evaluation of the measures under consideration, NQF received one comment from one organization (one member organization) pertaining to the draft report and to the measures under consideration. All comments for each measure under consideration have been summarized in Appendix A.

Throughout the extended public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided an expression of support.

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: Fall 2019 Measures, Track 1

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 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.

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.

Summary of Measure Evaluation: Fall 2019 Measures, Measures Withdrawn

3492 Acute Care Use Due to Opioid Overdose (Yale CORE): Withdrawn by Developer

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 measure was later

withdrawn by the developer following the public comment period but before the Post-Comment Web Meeting.

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 concern that social risk factors are not distributed equally across states or counties. The developer shared that traditional factors like state-level poverty rates and state-level opioid overdose rates showed only a moderate relationship, and based on the intended measure use, it is important to be able to calculate rates that consider all factors. The Committee also noted that there is a validity concern about whether the healthcare sector can meaningfully influence the risk of opioid overdose given the challenge that illicit drug users do not otherwise have a high rate of engagement with healthcare providers. The developer noted that MATs, reduction in risky prescribing practices, and use of prescription drug monitoring programs represent actions that healthcare providers can take. The Committee also expressed a validity concern that the measure only used a sample from the Medicare Fee-for-Service population and no other data sources. Regarding the testing sample, the developer stated that performance in the Medicare Fee-for-Service population is not different from trends seen in the broader population. The Committee suggested that the developer consider expanding testing beyond the Medicare population in the future.

The Committee discussed that this is a public health measure and should only be used at the state or county level as specified. During the post-comment meeting, the Committee wanted to discuss whether

overdoses are coded appropriately. The Committee will discuss and revote on the measure during the post-comment web meeting on April 22, 2020.

References

1 Katz - The National Survey on Drug Use and Health: 2018
https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Assistant-Secretary-nsduh2018_presentation.pdf. Last accessed February 2020.

2 Kamal R. What are the current costs and outcomes related to mental health and substance abuse disorders? Peterson-Kaiser Health System Tracker. https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/. Published July 31, 2017. Last accessed February 2020.

3 Hunot V, Churchill R, Teixeira V, et al. Psychological therapies for generalised anxiety disorder. *Cochrane Database of Systematic Reviews*. 2007;(1). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001848.pub4/abstract. Last accessed February 2020.

4 Mattick et al. - 2014 - Buprenorphine maintenance versus placebo or methad.pdf. http://unmfm.pbworks.com/w/file/fetch/116281933/Buprenorphine%20or%20methadone%20for%20OUD-%20Cochrane%20review.pdf. Last accessed February 2020.

5 Burgess SS, Geddes J, Hawton KK, et al. Lithium for maintenance treatment of mood disorders. *Cochrane Database of Systematic Reviews*. 2001;(3). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003013/abstract. Last accessed February 2020.

6 Subramanian et al. - 2017 - Clozapine dose for schizophrenia.pdf. https://www.researchgate.net/profile/Birgit_Voellm/publication/317614543_Clozapine_dose_for_schizophrenia/links/5a78da72a6fdcc4ffe90b74f/Clozapine-dose-for-schizophrenia.pdf?origin=publication_detail. Last accessed February 2020.

7 Hartung B, Wada M, Laux G, et al. Perphenazine for schizophrenia. *Cochrane Database of Systematic Reviews*. 2005;(1). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003443.pub2/abstract. Last accessed February 2020.

8 Arroll B, Elley CR, Fishman T, et al. Antidepressants versus placebo for depression in primary care. *Cochrane Database Syst Rev*. 2009;(3):CD007954.

9 Dennis C-L. Psychosocial and psychological interventions for prevention of postnatal depression: systematic review. *BMJ*. 2005;331(7507):15.

10 Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*. 2012;(10). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006525.pub2/abstract. Last accessed February 2020.

11 Waserstein G, Partin C, Cohen D, et al. The prevalence and impact of psychiatric symptoms in an undiagnosed diseases clinical program. *PLoS ONE*. 2019;14(6):e0216937.

12 Gentzke AS, Creamer M, Cullen KA, et al. Vital signs: tobacco product use among middle and high school students – United States, 2011-2018. *MMWR Morb Mortal Wkly Rep*. 2019;68(6):157-164.

13 Hu, SS, Homa DM, Wang T, et al. State-Specific Patterns of Cigarette Smoking, Smokeless Tobacco Use, and E-Cigaratte Use Among Adults. February 2020. https://www.cdc.gov/pcd/issues/2019/18_0362.htm.

14 Nyblade L, Stockton MA, Giger K, et al. Stigma in health facilities: why it matters and how we can change it. *BMC Med*. 2019;17(1):25.

15 Rentas KG, Buckley L, Wiest D, et al. Characteristics and behavioral health needs of patients with patterns of high hospital use: implications for primary care providers. *BMC Health Serv Res*. 2019;19(1):81.

16 The Lancet, ed. ICD-11. June 2019. https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(19)31205-X.pdf.

17 Scholl L, Seth P, Kariisa M, et al. Drug and Opioid-Involved Overdose Deaths – United States, 2013–2017. 2019;67:9.

18 CDC. More than a mental health problem. Centers for Disease Control and Prevention. https://www.cdc.gov/vitalsigns/suicide/index.html. Published November 27, 2018. Last accessed February 2020.

19 Alcohol Facts and Statistics | National Institute on Alcohol Abuse and Alcoholism (NIAAA). National Institute on Alcohol Abuse and Alcoholism. https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics. Published August 2018. Last accessed February 2020.

20 Roberts LW, Louie AK, Guerrero APS, et al. Premature mortality among people with mental illness: advocacy in academic psychiatry. *Acad Psychiatry*. 2017;41(4):441-446.

21 Mental Health Myths and Facts | MentalHealth.gov. MentalHealth.gov. https://www.mentalhealth.gov/basics/mental-health-myths-facts. Published August 9, 2017. Last accessed February 2020.

22 Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington (DC): National Academies Press (US); 2006. http://www.ncbi.nlm.nih.gov/books/NBK19830/. Last accessed February 2020.

23 Schaefer JA, Ingudomnukul E, Harris AHS, et al. Continuity of care practices and substance use disorder patients' engagement in continuing care. *Med Care*. 2005;43(12):1234-1241.

24 Duckworth M.D. K, Hosking PhD. R, Brister PhD. T, et al. Advancing Discovery for New, Better Treatments | NAMI: National Alliance on Mental Illness. February 2019. https://www.nami.org/About-NAMI/NAMI-News/2019/Advancing-Discovery-for-New-Better-Treatments. Last accessed February 2020.

25 Tanenbaum SJ. Evidence-based practice as mental health policy: three controversies and a caveat. *Health Affairs*. 2005;24(1):163-173.

26 Weil AR. Behavioral health. *Health Affairs*. 2016;35(6):955-955.

27 Whitaker R. *Anatomy of an Epidemic by Robert Whitaker | PenguinRandomHouse.Com: Books*. Crown (Random House): Crown Publishing Group; 2010. https://www.penguinrandomhouse.com/books/189611/anatomy-of-an-epidemic-by-robert-whitaker/9780307452429. Last accessed February 2020.

28 Tiihonen J, Taipale H, Mehtälä J, et al. Association of antipsychotic polypharmacy vs monotherapy with psychiatric rehospitalization among adults with schizophrenia. *JAMA Psychiatry*. 2019;76(5):499.

29 Katona L, Czobor P, Bitter I. Real-world effectiveness of antipsychotic monotherapy vs. polypharmacy in schizophrenia: to switch or to combine? A nationwide study in Hungary. *Schizophrenia Research*. 2014;152(1):246-254.

Appendix A: Details of Measure Evaluation

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

Track 1 – 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: <u>The measure meets the Importance criteria</u>** (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: <u>The measure meets the Scientific Acceptability criteria</u> (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; 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-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.
  - o Some members felt that the measure should not be very difficult to influence.
  - o 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

No comments received.

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

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

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(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**

<u>Rationale</u>:

- 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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.

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT

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; 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-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

No comments received.

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 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.

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.

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

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

Measure Steward: Pharmacy Quality Alliance

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

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(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**

<u>Rationale</u>:

- 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.
  - 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).
  - 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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).
  - 52 of 62 Medicare Prescription Drug Plans (PDPs) had at least 100 beneficiaries in the denominator.
  - 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.
  - 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 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)

<u>Rationale</u>:

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

<u>Rationale</u>:

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

- 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

This measure reflects the evolving standard of care; APA agrees that it is important to screen for drug use in patients on long-term opioid therapy. However, as noted in the evidence submission for this measure, there is limited evidence supporting the specific schedule of annual urine drug screening. Nevertheless, the evidence does support drug screening for patients on long-term opioid therapy in general, and APA finds the selection of annual monitoring as a basis for performance measurement to be appropriate at this time.

8. Consensus Standards Approval Committee (CSAC) Vote:

9. Appeals

Measures Withdrawn Prior to Post-Comment Meeting

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-18; 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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**

<u>Rationale</u>:

- 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

Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Program
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)

---

[a] Per CMS Measures Inventory Tool as of February 28, 2020

0105e	Antidepressant Medication Management (AMM) (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid (Implemented 2018) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016)
0108e	Follow-Up Care for Children Prescribed ADHD Medication (ADD) (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Medicaid (Implemented 2018)
0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0560	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Hospital Compare (Implemented 2013) Inpatient Psychiatric Quality Reporting (Implemented 2013)
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2015) Medicaid (Implemented 2013)
0640	HBIPS-2 Hours of physical restraint use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0641	HBIPS-3 Hours of seclusion use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)

0710e	Depression Remission at Twelve Months (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0711	Depression Remission at Six Months	Merit-Based Incentive Payment System (MIPS) Program (Implemented 2018/Scheduled Removal 2021))
0712e	Depression Utilization of the PHQ-9 Tool (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
1365e	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid (Implemented 2013)
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Medicaid (Implemented 2018)
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Medicaid (Implemented 2018)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid (Implemented 2017)
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	Merit-Based Incentive Payment System (MIPS) Program (Finalized 2018/Scheduled for implementation 2020)

Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

STANDING COMMITTEE

Peter Briss, MD, MPH (Co-Chair)
Medical Director, Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion
Chamblee, Georgia

Harold Pincus, MD (Co-Chair)
Director of Quality and Outcomes Research, New York-Presbyterian Hospital, The University Hospital of Columbia and Cornell
New York City, New York

Mady Chalk, PhD, MSW
Senior Policy Advisor, Treatment Research Institute
Washington, District of Columbia

David Einzig, MD
Children's Hospital And Clinics Of Minnesota
Saint Paul, Minnesota

Julie Goldstein Grumet, PhD
Director of Prevention and Practice, Education Development Center/Suicide Prevention Resource Center/National Action Alliance for Suicide Prevention
Washington, District of Columbia

Charles Gross, PhD
Vice President, Behavioral and Physical Health Integration, Anthem, Inc.
Hanover, Maryland

Constance Horgan, ScD (*Inactive*)
Professor and Director, Institute for Behavioral Health, The Heller School for Social Policy and Management, Brandeis University
Waltham, Massachusetts

Lisa Jensen, DNP, APRN
Associate Director Workforce and Leadership, Office of Nursing Services, Veteran's Health Administration
North Salt Lake, Utah

Dolores (Dodi) Kelleher, MS, DMH
Principal, D Kelleher Consulting
Alameda, California

Kraig Knudsen, PhD

Chief, Bureau of Research and Evaluation, Ohio Department of Mental Health and Addiction Services
Columbus, Ohio

Michael R. Lardieri, LCSW
Assistant Vice President Strategic Program Development, Northwell Health, Behavioral Health Services Line
Glen Oaks, New York

Tami L. Mark, PhD, MBA
Senior Director, Behavioral Health and Criminal Justice, RTI International
Bethesda, Maryland

Raquel Mazon Jeffers, MPH, MIA
Director of Health Integration, The Nicholson Foundation
Hopewell, New Jeresy

Bernadette Melnyk, PhD, RN, CPNP/PMHNP, FAANP, FNAP, FAAN
Associate Vice President for Health Promotion, University Chief Wellness Officer, Dean and Professor, College of Nursing, Professor of Pediatrics and Psychiatry, College of Medicine, The Ohio State University
Columbus, Ohio

Laurence Miller, MD
Senior Psychiatrist, Arkansas Medicaid; Clinical Professor of Psychiatry, University of Arkansas for Medical Sciences
Little Rock, Arkansas

Brooke Parish, MD
Physician Surveyor, Health Care Service Corporation - Blue Cross Blue Shield of New Mexico
Albuquerque, New Mexico

David Pating, MD
Chief, Addiction Medicine, Kaiser Permanente
San Francisco, California

Vanita Pindolia, PharmD, MBA
Vice President, Ambulatory Clinical Pharmacy Programs, Henry Ford Health System(HFHS)/Health Alliance Plan (HAP)
Detroit, Michigan

Lisa Shea, MD, DFAPA
Director of Quality of the Adult Psychiatric Service Line, Lifespan
Providence, Rhode Island

Andrew Sperling, JD
Director of Federal Advocacy, National Alliance on Mental Illness
Arlington, Virginia

Jeffery Susman, MD
Dean, Northeast Ohio Medical University, Northeast Ohio Medical University
Rootstown, Ohio

Michael Trangle, MD
Senior Medical Director, Behavioral Health Division, HealthPartners Medical Group, Regions Hospital
Minnetonka, Minnesota

Bonnie Zima, MD, MPH
Professor in Residence, Child and Adolescent Psychiatry, University of California, Los Angeles (UCLA)
Semel Institute for Neuorscience and Human Behavior
Los Angeles, California

Leslie S. Zun, MD, MBA
System Chair, Department of Emergency Medicine, Sinai Health System
Chicago, Illinois

NQF STAFF

Kathleen Giblin, RN
Acting Senior Vice President, Quality Measurement

Apryl Clark, MHSA
Acting Vice President, Quality Measurement

Samuel Stolpe, PharmD, MPH
Senior Director

Nicolette Mehas, PharmD
Director

Tamara Funk, MPH
Project Manager

Hannah Bui, MPH
Project Analyst

Udobi Onyeuku, MSHA
Project Analyst

Appendix D: Measure Specifications (Tabular)

	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 DESCRIPTION / PRESCRIPTION Miscellaneous antipsychotic agents / Aripiprazole; Asenapine; Brexpiprazole; Cariprazine; Clozapine; Haloperidol; Iloperidone; Loxapine; Lurisadone; Molindone; Olanzapine; Paliperidone; Pimozide; Quetiapine; Quetiapine fumarate, Risperidone, Ziprasidone

	2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics
	Phenothiazine antipsychotics / Chlorpromazine; Fluphenazine; Perphenazine; Thioridazine; Trifluoperazine
	Thioxanthenes / Thiothixene
	Long-acting injections / Aripiprazole; Fluphenazine decanoate; Haloperidol decanoate; Olanzapine; Paliperidone palmitate; Risperidone
	Psychotherapeutics combinations / Fluoxetine-olanzapine; Perphenazine-amitriptyline
	Phenothiazine antipsychotics / Prochlorperazine
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:
	• 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
Copyright / Disclaimer	The HEDIS® measures and specifications were developed by and are owned by the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for a non-commercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA.
	©2019 NCQA, all rights reserved.
	Calculated measure results, based on unadjusted HEDIS specifications, may not be termed "Health Plan HEDIS rates" until they are audited and designated reportable by an NCQA-

	2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics
	Certified Auditor. Such unaudited results should be referred to as "Unaudited Health Plan HEDIS Rates." Accordingly, "Heath Plan HEDIS rate" refers to and assumes a result from an unadjusted HEDIS specification that has been audited by an NCQA-Certified HEDIS Auditor.
	Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.
	Content reproduced with permission from HEDIS, Volume 2: Technical Specifications for Health Plans. To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit www.ncqa.org/publications.

	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.

	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
	-- 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
Copyright / Disclaimer	The HEDIS® measures and specifications were developed by and are owned by the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for a non-commercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2019 NCQA, all rights reserved. Calculated measure results, based on unadjusted HEDIS specifications, may not be termed "Health Plan HEDIS rates" until they are audited and designated reportable by an NCQA-Certified Auditor. Such unaudited results should be referred to as "Unaudited Health Plan HEDIS Rates." Accordingly, "Heath Plan HEDIS rate" refers to and assumes a result from an unadjusted HEDIS specification that has been audited by an NCQA-Certified HEDIS Auditor.

	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
	Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. Content reproduced with permission from HEDIS, Volume 2: Technical Specifications for Health Plans. To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit www.ncqa.org/publications.

	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.

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

	3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	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
	Type of Bill (TOB) Codes – 0810, 0811, 0812, 0813, 0814, 0815, 0817, 0818, 0819, 0820, 0821, 0822, 0823, 0824, 0825, 0827, 0828, 0829, 081A, 081B, 081C, 081D, 081E, 081F, 081G, 081H, 081I, 081J, 081K, 081M, 081O, 081X, 081Y, 081Z, 082A, 082B, 082C, 082D, 082E, 082F, 082G, 082H, 082I, 082J, 082K, 082M, 082X, 082Y, 082Z
	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 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_508.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:

	3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	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
Copyright / Disclaimer	Rights retained by PQA, Inc 2019.
	Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.
	CPT[R] contained in the measure specifications is copyright 2004-2017 American Medical Association.
	ICD-10 copyright 2017 World Health Organization. All Rights Reserved.
	LOINC[R] copyright 2004-2017 Regenstrief Institute, Inc.
	Uniform Bill Codes copyright 2017 American Hospital Association. All rights reserved.
	Due to technical limitations, registered trademarks are indicated by (R) or [R].

Appendix D: Measure Specifications (Narrative)

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

DESCRIPTION / PRESCRIPTION

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; Thioridazine; Trifluoperazine

Thioxanthenes / Thiothixene

Long-acting injections / Aripiprazole; Fluphenazine decanoate; Haloperidol decanoate; Olanzapine; Paliperidone palmitate; Risperidone

Psychotherapeutics combinations / Fluoxetine-olanzapine; Perphenazine-amitriptyline

Phenothiazine antipsychotics / Prochlorperazine

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

• 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

COPYRIGHT / DISCLAIMER

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

DESCRIPTION / PRESCRIPTION

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; Thioridazine; Trifluoperazine

Thioxanthenes / Thiothixene

Long-acting injections / Aripiprazole; Fluphenazine decanoate; Haloperidol decanoate; Olanzapine; Paliperidone palmitate; Risperidone

Psychotherapeutic combinations / Fluoxetine-olanzapine; Perphenazine-amitriptyline

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

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

Type of Bill (TOB) Codes – 0810, 0811, 0812, 0813, 0814, 0815, 0817, 0818, 0819, 0820, 0821, 0822, 0823, 0824, 0825, 0827, 0828, 0829, 081A, 081B, 081C, 081D, 081E, 081F, 081G, 081H, 081I, 081J, 081K, 081M, 081O, 081X, 081Y, 081Z, 082A, 082B, 082C, 082D, 082E, 082F, 082G, 082H, 082I, 082J, 082K, 082M, 082X, 082Y, 082Z

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 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_508.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. 135614

COPYRIGHT / DISCLAIMER

Appendix E: Related and Competing Measures (Tabular)

Comparison of NQF #2800 and NQF #1932

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
Steward	National Committee for Quality Assurance	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.	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.
Type	Process	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. No data collection instrument provided Attachment 2800_APM_Value_Sets_Fall_2019.xlsx	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
Level	Health Plan	Health Plan, Integrated Delivery System, Population : Regional and State
Setting	Emergency Department and Services, Outpatient Services	Other, Outpatient Services Any outpatient setting represented with Medicaid claims data
Numerator Statement	Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.	Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening 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	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.

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	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).	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.
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 DESCRIPTION / PRESCRIPTION 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; Thioridazine; Trifluoperazine Thioxanthenes / Thiothixene	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.

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	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 BH Acute Inpatient POS 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.

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
		- 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.

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
		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).
		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).
		- 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.
		- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).
		PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):
		Alpha-glucosidase inhibitors:
		Acarbose, Miglitol
		Amylin analogs:
		Pramlinitide
		Antidiabetic combinations:
		Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin
		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

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
		Meglitinides:
		Nateglinide, Repaglinide
		Glucagon-like peptide-1 (GLP1) agonists:
		Dulaglutide, Exenatide, Liraglutide, Albiglutide
		Sodium glucose cotransporter 2 (SGLT2) inhibitor:
		Canagliflozin, Dapagliflozin, Empagliflozin
		Sulfonylureas:
		Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide
		Thiazolidinediones:
		Pioglitazone, Rosiglitazone
		Dipeptidyl peptidase-4 (DDP-4) inhibitors:
		Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

		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.
		ANTIPSYCHOTIC MEDICATIONS:
		(Antipsychotic Medications List)
		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, Prochlorperazine, Thioridazine, Trifluoperazine
		Thioxanthenes:
		Thiothixene

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
		Long-acting injections: Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone (Antipsychotic Combination Medications List) Psychotherapeutic combinations: Fluoxetine-olanzapine, Perphenazine-amitriptyline See corresponding Excel document for the value sets referenced above.
Risk Adjustment	No risk adjustment or risk stratification	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).	None.
Type Score	Rate/proportion better quality = higher 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.	Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year. Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria: - Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. - Patients with diabetes during the measurement year or the year prior to the measurement year. - Patients who had no antipsychotic medications dispensed during the measurement year. Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year. Step 4. Calculate the rate.
Submission items	5.1 Identified measures: 1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	5.1 Identified measures: 1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

	2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics	1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
	5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: 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.

5b.1 If competing, why superior or rationale for additive value: N/A | 1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A |

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	Pharmacy Quality Alliance	RAND Corporation/UCLA	Pharmacy Quality Alliance	Pharmacy Quality Alliance	Pharmacy Quality Alliance	Centers for Medicare & Medicaid Services	PQA, Inc.
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.	Percentage of vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed	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.	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.	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.	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)	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	Process	Process	Process	Process	Process	Process	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	Paper Medical Records Medical record abstraction tool No data collection instrument provided No data dictionary	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	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	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	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	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

	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)
	Medicare enrollees but may consider this measure for the future. No data collection instrument provided Attachment AMO_CompleteCoding_UPDATED-637002672397479085.xlsx						
Level	Health Plan	Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual	Health Plan, Other, Population : Regional and State	Health Plan, Other, Population : Regional and State	Health Plan, Other, Population : Regional and State	Facility	Health Plan
Setting	Outpatient Services	Home Care, Inpatient/Hospital, Outpatient Services	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.	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.	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.	Emergency Department and Services, Inpatient/Hospital	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	Individuals in the denominator population who have not received a drug test during the measurement year.	Patients from the denominator that are given a bowel regimen or there is documentation as to why this was not needed	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	Any member in the denominator who received opioid prescription claims from 4 or more prescribers AND 4 or more pharmacies.	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	Patients prescribed two or more opioids or an opioid and benzodiazepine at discharge.	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	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."	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.	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	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.	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	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	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

	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)
			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) fentanyl buccal or SL tablets, or lozenze/troche (0.13) fentanyl film or oral spray (0.18)		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	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 datatype and value set 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/.	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)

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)
		fentanyl nasal spray (0.16) fentanyl patch (7.2) hydrocodone (1) hydromorphone (4) levorphanol (11) meperidine (0.1) methadone (3) morphine (1) opium (1) oxycodone (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., BunavailTM, 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)		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) buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) 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) opium (1) oxycodone (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., BunavailTM, Suboxone®, Zubsolv®) are excluded from the MED calculations. Ionsys®		

	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)
					(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)		
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.	Vulnerable adults who are given a prescription for an opioid	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.	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 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.	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	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	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 Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying	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	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	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	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:	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, where 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:

	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)
	prescribed as chronic pain medications. Medications prescribed or provided as part of medication-assisted treatment for opioid use disorder are excluded from the calculation.	vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699				- 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.	• 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	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.	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 (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 (Medicare Part D) 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.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	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	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	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	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	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:

	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)
	Type of Bill (TOB) Codes – 0810, 0811, 0812, 0813, 0814, 0815, 0817, 0818, 0819, 0820, 0821, 0822, 0823, 0824, 0825, 0827, 0828, 0829, 081A, 081B, 081C, 081D, 081E, 081F, 081G, 081H, 081I, 081J, 081K, 081M, 081O, 081X, 081Y, 081Z, 082A, 082B, 082C, 082D, 082E, 082F, 082G, 082H, 082I, 082J, 082K, 082M, 082X, 082Y, 082Z 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."	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.					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	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Not applicable.		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	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 Feder	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 Feder	Not applicable; this measure is not stratified.	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	Rate/proportion better quality = lower score	Rate/proportion better quality = higher score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower 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 technical guidance specific to the Health Insurance Marketplace Quality Rating System (QRS), available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-	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	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:	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	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:	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'.	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

	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)
	Instruments/QualityInitiativesGenInfo/Downloads/Revised_QRS-2018-Measure-Tech-Specs_20170929_508.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.	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.	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.	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.	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		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/MedicareAdvtgSpecRateStats/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

	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)
					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.		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 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	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)	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact:	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact:	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact:	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	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

	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)
	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.	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.	5b.1 If competing, why superior or rationale for additive value: N/A	5b.1 If competing, why superior or rationale for additive value: N/A	5b.1 If competing, why superior or rationale for additive value: N/A	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	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).

Appendix E: Related and Competing Measures (Narrative)

Behavioral Health and Substance Use, Fall 2019 Cycle Track 1: CDP Report Behavioral Health and Substance Use, Fall 2019 Cycle Track 1: 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)

buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) 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) opium (1) oxycodone (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., BunavailTM, 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)

buprenorphine patch (12.6) buprenorphine tab or film (10) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) 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) opium (1) oxycodone (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., BunavailTM, 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 datatype 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

Saliba D, Elliott M, Rubenstein LZ, et al. The vulnerable elders survey: a tool for identifying vulnerable older people in the community. J Amer Geriatr Soc 2001;48:1691-1699

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

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

Type of Bill (TOB) Codes – 0810, 0811, 0812, 0813, 0814, 0815, 0817, 0818, 0819, 0820, 0821, 0822, 0823, 0824, 0825, 0827, 0828, 0829, 081A, 081B, 081C, 081D, 081E, 081F, 081G, 081H, 081I, 081J, 081K, 081M, 081O, 081X, 081Y, 081Z, 082A, 082B, 082C, 082D, 082E, 082F, 082G, 082H, 082I, 082J, 082K, 082M, 082X, 082Y, 082Z

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 Feder

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 Feder

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_508.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.

3316e: 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/MedicareAdvtgSpecRateStats/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.

• 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 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

3316e: 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).

Appendix F: Pre-Evaluation Comments

Comments received as of January 21, 2020.

Topic	Commenter	Comment
3492: Acute Care Use Due to Opioid Overdose – MEASURE WITHDRAWN	Submitted by Academic Pediatric Association	I support the adoption of this measure.
3492: Acute Care Use Due to Opioid Overdose – MEASURE WITHDRAWN	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 – MEASURE WITHDRAWN	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.