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Patient Safety Spring 2020 Cycle: CDP Technical Report

TECHNICAL REPORT
MARCH 15, 2021

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-TO001.

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Contents

Executive Summary **3**
Introduction **4**
NQF Portfolio of Performance Measures for Patient Safety Conditions **5**
Table 1. NQF Patient Safety Portfolio of Measures 5
Patient Safety Measure Evaluation **5**
Comments Received Prior to Standing Committee Evaluation 5
Comments Received After Standing Committee Evaluation 6
Overarching Issues 6
Summary of Measure Evaluation 7
References **11**
Appendix A: Details of Measure Evaluation **12**
Endorsed Measures 12
2723 Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure 12
3558 Initial Opioid Prescribing for Long Duration (IOP-LD) 16
Appendix B: Patient Safety Portfolio—Use in Federal Programs **22**
Appendix C: Patient Safety Standing Committee and NQF Staff **26**
Appendix D: Measure Specifications **30**
2723 Wrong-Patient Retract-and-Reorder (Wrong Patient-RAR) Measure 30
3558 Initial Opioid Prescribing for Long Duration (IOP-LD) 32
Appendix E1: Related and Competing Measures (tabular format) **38**
Appendix E2: Related and Competing Measures (narrative format) **90**
Appendix F: Pre-Evaluation Comments **162**

Executive Summary

Medical errors and adverse events are major threats to patient safety in healthcare and are linked to more than 100,000 preventable deaths per year in the United States (US).[1] Patient safety-related events occur across all settings, including hospitals and outpatient clinics, as well as nursing homes, rehabilitation facilities, and others. Patient safety-related events include a variety of preventable outcomes, including healthcare-associated infections, falls, and pressure ulcers.

The National Quality Forum (NQF) holds a portfolio of safety measures spanning a variety of topical areas; it also includes outcomes as well as important, measurable processes in healthcare that are associated with patient safety. Public accountability and quality improvement programs use many measures from NQF's portfolio. Nevertheless, significant gaps in patient safety persist. Over more than a decade, NQF's portfolio has expanded to address current and evolving public health issues, such as the opioid crisis. As electronic health records (EHRs) have become increasingly prevalent in healthcare, it is important to develop measures that monitor and improve safety events that may be caused by the technology itself.

The Patient Safety Standing Committee oversees the NQF patient safety measure portfolio. The Standing Committee evaluates newly submitted and previously endorsed measures against NQF's measure evaluation criteria, identifies portfolio gaps, provides feedback on gaps in measurement, and conducts ad hoc reviews. On June 18 and 19, 2020, the Patient Safety Standing Committee evaluated two measures against NQF's standard evaluation criteria.

Critical issues discussed during the meetings included that measures should be integrated into the design of EHRs, and measures should be feasibly adopted without barriers or potential limitations, such as high licensing fees that may limit their use.

For this cycle, the Standing Committee evaluated one newly submitted measure and one measure undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended both measures for endorsement. The measures are:

- **NQF #2723** Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure (NewYork-Presbyterian Hospital); and
- **NQF #3558** Initial Opioid Prescribing for Long Duration (IOP-LD) (Pharmacy Quality Alliance)

Brief summaries of the measures are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Introduction

The Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, published in 2000, created a national movement by individuals and institutions to closely examine the avoidable harms in healthcare. These included hospital-based medical errors, adverse drug events (ADEs), injuries from surgery, falls, pressure ulcers, and other causes of preventable morbidity and mortality.

Despite 20 years of progress since the publication of that report, medical errors and other patient safety events remain common across all settings of care. There has been demonstrated improvement in specific areas, including the reduction of hospital-acquired infections. Yet, the scale of improvements in patient safety has been limited. Many interventions to improve patient safety have been effective, but many others have proven otherwise. Today, patients commonly experience potentially preventable harm, including ADEs. It is estimated that medical errors are the third leading cause of deaths in the US with more than 250,000 deaths per year.[2]

An ADE refers to harm resulting from a medication. For decades, there has been increased attention on the use of pain medications, namely opioids, as their misuse, addiction, and overdose have created a public health crisis affecting social and economic welfare in the US.[3] Prescription opioids for pain management remain a contributing factor to the crisis. It is estimated that approximately 21-29 percent of patients who are prescribed opioids for chronic pain misuse them.[4] Research suggests that an initial opioid prescription of greater than seven days' supply is associated with a significant increase in high-risk opioid use.[5] Therefore, there has been increased interest from the public health community to limit the duration of initial opioid use.[6,7] In this cycle, the Patient Safety Standing Committee reviewed one measure that evaluates initial opioid prescriptions to help monitor and potentially mitigate unsafe opioid use.

Healthcare providers are increasingly being held accountable for improving patient safety and the quality-of-care delivery through the use of quality measurement and public reporting. Measurement and quality improvement activities can incentivize the healthcare system to reduce potentially preventable patient safety events, develop effective processes to remediate issues that occur, and build a culture of organizational safety. NQF's Patient Safety Standing Committee is a long-standing group who convenes regularly to assess patient safety measures, identify measure gaps, and operate as a thought leader in the next generation of approaches to improve safety across all settings. NQF has endorsed 34 safe practices in the Safe Practices for Better Healthcare report and 29 Serious Reportable Events (SRE). The Safe Practices, SREs, and NQF-endorsed patient safety measures are important tools for tracking and improving patient safety performance in American healthcare.

Additionally, with the increasing ubiquity of electronic health records (EHRs), there has been increased interest in measures that can be automatically extracted from EHRs. In this cycle, the Patient Safety Standing Committee reviewed one measure that leveraged the EHR to identify and monitor when providers place a wrong order for a patient. These wrong-patient errors (i.e., patient identification errors) have been identified as a serious and common health information technology safety hazard that requires prevention strategies.[8]

NQF Portfolio of Performance Measures for Patient Safety Conditions

The Patient Safety Standing Committee (Appendix C) oversees NQF's portfolio of Patient Safety measures (Appendix B). This portfolio contains 60 measures: 16 process measures, 37 outcome measures, one intermediate outcome measure, three structure measures, and three composite measures (see Table 1 below).

Table 1. NQF Patient Safety Portfolio of Measures

	Process	Outcome	Intermediate Outcome	Structure	Composite	Total
Medication Safety	8	1	0	0	0	9
Healthcare-Associated Infections	2	7	0	0	0	9
Perioperative Safety	0	7	0	0	0	7
Falls	1	5	0	0	0	6
Mortality	0	7	0	0	1	8
Venous Thromboembolism	0	1	0	0	0	1
Pressure Ulcers	0	3	0	0	0	3
Workforce	0	0	0	3	0	3
Radiation Safety	0	0	1	0	0	1
Other	5	6	0	0	2	13
Total	16	37	1	3	3	60

Additional measures have been assigned to other portfolios. These include various diabetes assessment and screening measures (Prevention and Population Health/Behavioral Health and Substance Use), pediatric measures (Primary Care and Chronic Illness), Angiotensin-Converting-Enzyme Inhibitors (ACEI)/Angiotensin Receptor Blockers(ARB) medication measures (Cardiovascular), complications measures (Prevention and Population Health/Surgery), and cost and efficiency measures (Cost and Efficiency).

Patient Safety Measure Evaluation

On June 18 and 19, 2020, the Patient Safety Standing Committee evaluated one new measure and one measure undergoing maintenance review against NQF's standard measure evaluation criteria (Table 2).

Table 2. Patient Safety Measure Evaluation Summary

	Maintenance	New	Total
Reviewed Measures review	1	1	2
Endorsed Measures	1	1	2

Comments Received Prior to Standing Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF accepts 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 April 3, 2020 and closed on August 25, 2020. Two comments were submitted and shared with the Standing Committee prior to the measure evaluation meeting(s) (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on August 25, 2020. Following the Standing Committee's evaluation of the measures under review, NQF received nine comments pertaining to the draft report and to the measures under review. All comments for each measure under review have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support (either "*support"* or "*do not support"*) for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations. One NQF member provided their expression of "*support"* and one expressed "*do not support"* for one of the two measures under review. Results are provided below.

Measure #3558: Initial Opioid Prescribing for Long Duration (IOP-LD) (Pharmacy Quality Alliance)

Member Council	Support	Do Not Support	Total
Health Professional	1	1	2

Overarching Issues

During the Standing Committee's discussion of the measures, overarching issues emerged that were factored into the Standing Committee's ratings and recommendations for the two measures reviewed this cycle. Those issues are summarized below.

Designing Measures That Can Be Designed to Work Within EHRs

With increased use of EHRs and their near ubiquity across healthcare facilities, it will be increasingly important to embed quality measures into EHR systems. In particular, the *Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR)* measure was viewed as the type of measure that could be built into EHRs, and inferences from its study could be used for the general design of EHRs (i.e., not allowing for multiple patient records to be open at the same time to reduce the incidence of wrong-patient orders).

Reduce Barriers to Measure Use

The Standing Committee discussed the importance of ensuring that measures are available to a wide variety of stakeholders and that there are no barriers to feasibility, such as high licensing fees associated with measure adoption and use. For instance, developers may license their measures depending on intended use (e.g., commercial use). This was a concern expressed by the Standing Committee in that certain licensing fees may have an impact on the adoption and use of important measures.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues and discussion points addressed by the Standing Committee. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A. Quorum was achieved and maintained throughout the entirety of the measure evaluation proceedings.

#2723 Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure (NewYork-Presbyterian Hospital): Endorsed

Description: A Wrong-Patient-RAR event occurs when an order is placed on a patient within an EHR, is retracted within 10 minutes, and then the same clinician places the same order on a different patient within the next 10 minutes. A Wrong-Patient Retract-and-Reorder Rate is calculated by dividing wrong patient-RAR events by total orders examined. **Measure Type**: Process; **Level of Analysis**: Facility, Integrated Delivery System; **Setting of Care**: Emergency Department and Services, Inpatient/Hospital, Outpatient Services; **Data Source**: Electronic Health Data, Electronic Health Records, Other

The Standing Committee recommended the measure for continued endorsement. Originally endorsed in 2015, the focus of the measure is to identify when providers place an order on the wrong patient, retract it within 10 minutes, and then the same provider places the same order on a different patient within the next 10 minutes. Standing Committee members asked for clarity regarding the intent of the measure, specifically if the measure is capturing human error or information technology (IT) error. The developer responded, stating that the measure currently captures whether a provider catches the error. The Standing Committee agreed that this is an important focus area of measurement. However, they would recommend that this measure, or a future version, focus more on the design features of the EHR systems, such that there would be an incentive to change these systems to prevent these errors. The developer agreed and stated that as more and more interventions are developed by health systems, measure #2723 could become a measure of the optimization and success of the EHR. One Standing Committee member asked why the measure uses 10 minutes. The developer stated that 10 minutes optimized the sensitivity and specificity of the measure.

Concerning the evidence criterion, some Standing Committee members questioned the potential for avoiding a serious event or unintended consequences with this measure. Specifically, since the measure captures "near misses," the Standing Committee questioned whether there has been evidence showing the impact of this measure on errors that cause significant harm. The developer stated that they are currently attempting to explore the associations of this measure and the impact of errors that reach the patient. The Standing Committee agreed that this is an important metric, which can lead to further EHR design optimization rather than provider vigilance. The Standing Committee observed that there is an appropriate measure performance gap and did not express any concerns. Regarding reliability, a Standing Committee member questioned if there was a specific code that is needed for implementation and recommended that those instructions, along with specifying the reporting period, be incorporated into the measure specifications. The developer confirmed that code would be needed for certain EHR systems and agreed to add these changes to the measure specifications in future versions of the measure.

Moving to validity, the Standing Committee raised some concern over the accuracy of provider self-report to confirm the retract and reorder event. The developer mentioned that the validity testing found sufficient accuracy in provider self-report of retract and reorders, but it may be higher since some providers may not confirm that they placed a wrong order. The developer also reiterated that they are looking into evaluating the association of this measure to errors that reach the patient. The measure was regarded as feasible by the Standing Committee with no concerns.

In their discussions related to usability and use, the Standing Committee noted that the measure is currently not in use. However, the developer provided a rationale on the recommendations for its potential use, including the use of the measure by the Leapfrog Group. The Standing Committee did question whether the measure was intended for quality improvement or public reporting. There was discussion on if the measures could be submitted for endorsement as a quality improvement metric. NQF staff clarified that, currently, there is no designation of "quality improvement." However, the Standing Committee recognized that the measures can and have been used as such. The Standing Committee observed that there are no related measures for this metric and voted to recommend the measure for continued endorsement.

Comments received during the public commenting period focused on validity and measure rate as a function of the number of prescriptions ordered and the use of the term "provider" as compared to "clinician". The developer mentioned on the call that the measure captures self-caught errors, which has been endorsed by several different groups, including NQF. The developer also described the theoretical model that associated near misses with actual wrong patient safety orders that had not been fully linked; yet, conceptually near misses captured in this measure are designed as a proxy for actual error. The Standing Committee further stated that the measure may be an indirect measure of EHR usability and compliance for best practices at the system measure rather than holding individuals accountable for personal failures, which is the intent of the measure. However, the Standing Committee was reminded by NQF staff that they previously reviewed these issues and passed the measure on importance and validity during the June 2020 meeting. The Standing Committee also recommended that the developer be more consistent with the term used to describe a clinician in future updates to the measure.

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD) (Pharmacy Quality Alliance): Endorsed

Description: The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Enrollment Data

The Standing Committee recommended the measure for initial endorsement.

The focus of the measure is to identify individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply. Concerning the evidence criterion, Standing Committee members were concerned with the higher measure rate found in the Medicare population and if the measure excludes individuals in hospice, palliative care, or those with certain social determinants of health. The developer stated that higher rates of opioid use have been reported among hospice patients in the primary literature and that, currently, the measure does exclude hospice patients. The measure does not exclude patients in palliative care nor those with certain social

determinants, but the developer is looking to explore these exclusions in the future. The Standing Committee also questioned why the developer chose a 90-day lookback period for defining opioid naïve patients. The developer stated that this varies within the literature. The developer also noted that they analyzed various lookback periods in the data and engaged a Technical Expert Panel (TEP) who identified that a 90-day lookback period was the optimal timeframe. They further noted that going beyond 90- 120 days did not affect the measure rates and that smaller windows of time were too conservative. The Standing Committee observed that there is an appropriate measure performance gap in care and did not express any concerns.

Regarding reliability, a Standing Committee member questioned if the measure is intended to have a mixed data set of commercial, Medicare, and Medicaid. The developer clarified that the measure would be implemented at different lines of business, rather than having multiple lines being mixed into one measure rate (i.e., mixing commercial, Medicare, and Medicaid). One Standing Committee member questioned whether the measure is sensitive to claims restrictions that a health plan may place on opioid medications. The developer stated that if there are any health plan point-of-sale edits or restrictions, the pharmacy would not be able to file the claim and this would not be captured. For validity, a Standing Committee member questioned why there was limited variability in the commercial population. The developer mentioned that the commercial testing was limited to only three health plans, which is driving the limited variation seen. There was some discussion on what the outcome or outcome measure would be to assess empirical validity, as the developer conducted face validity only. The developer stated that they could consider the prescription drug monitoring program to capture potential misuse as an outcome or if the measure is predictive for overdose.

The measure was regarded as feasible by the Standing Committee. However, there were concerns with respect to the licensing and how that may affect measure adoption. The developer stated that the licensing fee is charged for commercial use and government entities are not charged a fee. Additionally, there is not any reporting or feedback captured through the licensing.

In their discussions related to usability and use, the Standing Committee noted that the measure is planned to be used in the Centers for Medicare & Medicaid Services (CMS) Five Star Rating System for Medicare Part D. One Standing Committee member did ask for more clarity on its current use. The developer mentioned that the measure is currently implemented in a pilot program for the Enhanced Medication Therapy Management model through the CMS Center for Medicare & Medicaid Innovation. The results of this implementation have not been published to the public yet as the model is still ongoing. The Standing Committee observed that there are several related measures, all of which are measures stewarded by the developer. However, the Standing Committee did not raise any concerns with respect to harmonization and voted to recommend the measure for endorsement.

Comments received during the public commenting period addressed the evidence criterion not being met, potential for multiple opioid prescriptions being dispensed the same day for a single patient, inclusion of patients in Long-Term Care (LTC) settings, inclusion of methadone, CMS reporting requirements, and overall support of the Standing Committee's recommendation. During the post-comment deliberations, the Standing Committee reviewed the comments, proposed responses, and recommended to the developer that they continue to monitor for potential exclusions, such as LTC

settings and methadone, and for unintended consequences that are identified and if appropriate, to consider them in future updates of this measure.

References

1 Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press; 2000. https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system.

2 Makary MA, Daniel M. Medical error—the third leading cause of death in the US. *BMJ*. 2016;353. https://www.bmj.com/content/353/bmj.i2139. Last accessed July 2020.

3 National Institutes of Health/National Institute on Drug Abuse. Opioid Overdose Crisis. https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis. Published May 27, 2020. Last accessed February 2021.

4 Han B, Compton WM, Blanco C, et al. Prescription Opioid Use, Misuse, and Use Disorders in U.S. Adults: 2015 National Survey on Drug Use and Health. *Ann Intern Med*. 2017;167(5):293-301.

5 Zhang Y, Johnson P, Jeng PJ, et al. First Opioid Prescription and Subsequent High-Risk Opioid Use: a National Study of Privately Insured and Medicare Advantage Adults. *J Gen Intern Med*. 2018;33(12):2156-2162.

6 Shah A, Hayes CJ, Martin BC, et al. Factors Influencing Long-Term Opioid Use Among Opioid Naive Patients: An Examination of Initial Prescription Characteristics and Pain Etiologies. *J Pain*. 2017;18(11):1374-1383.

7 Dowell D, Haegerich TM, Chou R, et al. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. *MMWR Recomm Rep Morb Mortal Wkly Rep Recomm Rep*. 2016;65(1):1-49.

8 Mardon R, Olinger L, Szekendi M, et al. *Health Information Technology Adverse Event Reporting: Analysis of Two Databases*.; :28.

Appendix A: Details of Measure Evaluation

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

Note: Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present for that vote as the denominator.

Endorsed Measures

#2723 Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure

Submission | Specifications

Description: A Wrong-Patient-RAR event occurs when an order is placed on a patient within an EHR, is retracted within 10 minutes, and then the same clinician places the same order on a different patient within the next 10 minutes. Its rate is calculated by dividing Wrong-Patient-RAR events by total orders examined.

Numerator Statement: Wrong-Patient RAR events during a specified time period

Denominator Statement: All electronic orders placed during a specified time period

Exclusions: System-generated orders are excluded from the denominator. In some EHR systems, in addition to orders placed by clinicians, some orders are generated automatically by the EHR or other ancillary systems (e.g., the pharmacy system, the lab system, or other "interfaces"). Since these orders are not placed by an ordering clinician, they are not included in the denominator.

Adjustment/Stratification: No risk adjustment or stratification

Level of Analysis: Facility, Integrated Delivery System

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

Type of Measure: Process

Data Source: Electronic Health Data, Electronic Health Records, Other

Measure Steward: NewYork-Presbyterian Hospital

STANDING COMMITTEE MEETING June 18, 2020

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

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

1a. Evidence: **H-0; M-14; L-3; I-1**; 1b. Performance Gap: **H-0; M-17; L-1; I-0**

Rationale:

- The developer noted that there are healthcare actions that may reduce the incidence of Wrong-Patient-RAR, such as better system design (e.g., putting a patient's picture in the EHR to ensure that the orders are written on the right patient).
- The developer cited studies conducted at different healthcare settings (e.g., NICU, emergency department) showing reductions in wrong-patient order errors by displaying patient identification alerts when clinicians place orders in the EHR.
- The developer cited a 2013 validation study, conducted at Montefiore Medical Center, which found a Wrong-Patient-RAR Rate of 58 wrong-patient orders per 100,000 orders within a single year.
- The developer cited a 2015 study that was conducted at NewYork-Presbyterian Hospital in which a total of 3,457,342 electronic orders were recorded across five emergency departments and a total of 5,637 Wrong-Patient RAR events were identified: 163 per 100,000 orders (95% CI 159 - 167) within a 2.5-year study period (Dec 2010-June 2013).

#2723 Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure

- The developer showed data from six hospitals and health systems resulting in a range of Wrong-Patient RAR performance between 64-163 events per 100,000 patients.

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-11; M-6; L-1; I-0**; 2b. Validity: **H-4; M-12; L-2; I-0**

Rationale:

- The measure was tested for reliability in six healthcare systems. Test-retest and signal-to-noise reliability was assessed, across three different EHRs.
- The developer demonstrated that the data are highly reliable and repeatable, producing the exact same results when assessing the same population in the same time period. In >12 million orders, there were 7,128 Wrong-Patient-RAR events, with an event rate of 58 per 100,000 orders. Across three attempts (i.e., data pulls), the kappa score for inter-rater reliability was 1.0 compared to the first pull.
- The developer calculated a signal-to-noise ratio as a function of the variance between hospitals. Reliability was estimated using a beta-binomial model. In each of the six hospitals tested, the reliability score was 0.99 (near perfect). In addition, measure-level reliability was 0.99.
- One validation involved clinicians who triggered the measure. They were contacted within six to 12 hours of the occurrence to verify the event (in three health systems). The PPV range from 76.2% to 81.2% across published studies.
- Another validation approach involved the developer reporting studies evaluating different interventions aimed at preventing wrong-patient errors using the Wrong-Patient-RAR measure as the primary outcome of the study. Two studies described showed a significant decrease in Wrong-Patient-RAR events when using an intervention aimed at preventing wrong-patient errors. Another study demonstrated the impact on different EHR configurations, allowing clinicians to open varying numbers of workspaces at a time.

3. Feasibility: H-10; M-7; L-1; 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 data used are electronic clinical data (i.e., EHR, imaging/diagnostic study, laboratory, pharmacy, and registry) generated or collected by and used by healthcare personnel during the provision of care.
- All data elements are in defined fields in EHRs.

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-14; No Pass-4;** *4b. Usability:* **H-7; M-7; L-2; I-2**

Rationale:

- The developer stated the measure is currently not being used within an accountability program. However, at present, no regulatory body oversees or mandates public reporting or benchmarking of health IT safety measures.
- The measure is currently being evaluated for use as part of a “Leapfrog CPOE Evaluation Tool.”

#2723 Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure

- The 21st Century Cures Act has established a new Electronic Health Record Reporting Program, and this measure is being discussed as a possible measure for this program.
- Several citations were provided on recommendations for use by The Joint Commission, ECRI Institute, and the Office of the National Coordinator.

5. Related and Competing Measures

- No related or competing measures noted.

6. Standing Committee Recommendation for Endorsement: **Yes-14; No-4**

7. Public and Member Comment

- NQF received two comments on measure #2723. One commenter expressed concern on validity and measure rate as a function of number of prescriptions ordered.

  Measure Steward/Developer Response:
  Thank you for your comments. First, we agree that correlation between near-miss errors and errors that reach the patient is of interest. Nevertheless, the use of near-miss errors to test safety improvements in healthcare is endorsed by every major organization dedicated to improving patient safety, including the Agency for Healthcare Research and Quality, Institute of Medicine, World Health Organization, Institute for Healthcare Improvement, and The Joint Commission, because near-miss errors follow the same pathway as errors that cause harm. (1) Near-miss errors are invaluable in quality improvement efforts and patient safety research, as they occur up to 100 times more frequently than errors that reach the patient and thus provide a sufficient number of outcome events to test the effectiveness of safety interventions.[1]
  Second, the RAR rate is not risk-adjusted, but can be stratified by location, provider, patient, or order characteristics.
  1) Aspden P, Corrigan JM, Wolcott J, Erickson SM, eds. Patient Safety: Achieving a New Standard for Care. Washington (DC): National Academies Press (US); 2004. Patient Safety: Achieving a New Standard for Care.

- Another comment on the measure focused on the use of the term "provider" as compared to "clinician" and expanding the single focus of Wrong Patient Retract and Reorder (WPRAR) to include "reason-for-order cancellation".

  Measure Steward/Developer Response:
  Thank you for your comments and suggestions. First, we agree about the importance of understanding the reasons for order cancellations, which we have examined in validation studies of the measure and has been done in other studies of order errors (Adelman 2013, Hickman 2017, Abraham 2018). However, as the first and only fully automated measure of order errors in electronic health record (EHR) systems, the WPRAR measure serves to quantify the rate of wrong-patient orders for accountability, surveillance, and quality improvement activities.
  Second, placing orders for the wrong patient occurs frequently and has the potential to cause serious harm. We agree that there are other types of errors that are important to measure, and we are in the process of developing and validating additional measures of medication order errors. These RAR measures use Structured Query Language (SQL) queries that can be readily programmed into the EHR and other electronic data systems, without conducting labor-intensive chart review or relying on voluntary reporting of errors. Automated surveillance, in which electronic information systems are used to identify errors, has the potential to be a significantly more efficient and effective approach for identifying errors.
  Third, this measure has been used to evaluate the effectiveness of several different interventions aimed at improving patient identification and preventing wrong-patient orders in varied clinical settings, including the neonatal intensive care unit. Rates have been shown to be sensitive to change in response to intervention and to vary by clinical setting (inpatient vs emergency department vs

#2723 Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Measure
outpatient). The measure is an indicator of where improvement is needed and, importantly, provides a systematic method of measuring improvement. Finally, we recognize the inconsistent use of "provider" and "clinician". For future submissions, we will use the term "ordering clinician". We thank you again for your comments and suggestions.
8. Consensus Standards Approval Committee (CSAC) Vote (July 29, 2020): Y-11; N-0 Decision: Approved for continued endorsement
9. Appeals No appeals were received

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Submission | Specifications

Description: The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply

Numerator Statement: The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days (i.e., the three-day time period when the numerator is assessed).

Denominator Statement: The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

Exclusions: Individuals with cancer, sickle cell disease (SCD), or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

Adjustment/Stratification: 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 June 18, 2020

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

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

1a. Evidence: **H-7; M-13; L-0; I-0**; 1b. Performance Gap: **H-10; M-10; L-0; I-0**

Rationale:

- This new measure identifies individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply at the health plan level of analysis.
- The Standing Committee reviewed the evidence presented by the developer and sought clarification on the use of a 90-day lookback period for defining opioid naïve patients.
- The developer stated that they analyzed various lookback periods and presented the results to a Technical Expert Panel (TEP), which determined that the 90-day lookback period was optimal. The Standing Committee agreed with this approach.
- The Standing Committee considered the range of performance for Medicaid, Medicare Advantage, and commercial health plans with means of 23.7%, 43.8%, and 25.1%, respectively.
- Standing Committee members expressed concern with the higher rates found in Medicare. The developer stated that these rates are consistent with what is found in the primary literature.
- The Standing Committee ultimately agreed that the evidence provided supported the measure and that there is a gap in care that warrants a national performance measure.

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-13; M-6; L-0; I-0**; 2b. Validity: **H-0; M-18; L-2; I-0**

Rationale:

- The Standing Committee reviewed the results for reliability and validity.
- There was some discussion regarding the limited variability in the commercial population. The developer mentioned that the commercial testing was limited to only three health plans, which is what is driving the limited variation seen.
- Based on the mean reliability scores of 0.939 for Medicare, 0.982 for Medicaid, and 0.935 for commercial, the Committee agreed that the measure is considered reliable.

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

- The Committee considered that the developer conducted face validity only. The developer reported that a Technical Expert Panel concluded in 100% agreement that the scores obtained from the measure as specified will provide an accurate reflection of quality and that the measure can be used to distinguish good and poor quality between health plans.
- The Committee reviewed other threats to validity, including exclusions, and recommended that the developer consider excluding palliative care and certain social determinants in the future.
- While several considerations were noted on the reliability and validity of the measure, the Standing Committee agreed to pass the measure on scientific acceptability.

3. Feasibility: H-11; M-7; 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 Standing Committee agreed that the measure uses claims data that can be generated or collected during the provision of care and that there are no fees, licensing, or requirements to use the measure.
- The Standing Committee did express concerns regarding the measure licensing.
- The Standing Committee considered the developer's response that the licensing fee is charged for commercial use, and that government entities are not charged a fee, and ultimately passed the measure on feasibility.

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-0** *4b. Usability:* **H-8; M-10; L-0; I-1**

Rationale:

- The Standing Committee acknowledged that this measure is planned for use as part of CMS's Five Star Rating System for Part D.
- The Standing Committee noted that this is a new measure and there is no information available on performance improvement. This measure is not currently used in a program, but a primary goal of the measure is to provide information necessary to implement focused quality improvement efforts. Once the measure is implemented, the developer plans to examine trends in improvements over time.

5. Related and Competing Measures

- This measure is related with the following measures:
  - NQF #2940 Use of Opioids at High Dosage in Persons Without Cancer
  - NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer
  - NQF #2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
  - NQF #3389 Concurrent Use of Opioids and Benzodiazepines (COB)
  - NQF #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
- The Standing Committee did not raise any concerns as the measures are harmonized and stated that there are no competing measures.

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

7. Public and Member Comment

- NQF received two pre-evaluation comments and seven post-evaluation comments on measure #3558. Three post-evaluation comments were in support of the measure.

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Comments received expressed:

- Concerns about the evidence criterion; unintended negative consequences and the definition of "opioid naïve".

Measure Steward/Developer Response:
Pharmacy Quality Alliance (PQA) appreciates the Federation of American Hospitals (FAH)'s comments regarding the IOP-LD measure. Regarding the use of a 90-day lookback period, "lookback periods" are variably defined in the current literature, with some studies using 60-days and others up to 12 months. Considering Part D's opioid naïve edits, CMS recommends that Part D sponsors use a lookback of at least 60 days, with most sponsors using lookback periods between 60 and 120 days (4). PQA tested numerous lookback period options, including 30, 45, 90, and 120 days and discussed this question extensively with subject matter experts and Technical Expert Panels (TEPs). Ultimately, the TEP found the 30-day interval to be oversensitive in identifying prescriptions as initial, and there were inherent tradeoffs between sensitivity and specificity at each of the other lookback periods. Per testing, the overall impact of using different lookback periods was generally minor. As such, the TEP came to consensus that the 90-day lookback period is most appropriate.

PQA appreciates the American Medical Association (AMA)'s comments on the IOP-LD measure. Regarding the evidence to support the 7-day threshold, the 7-day threshold was chosen based on recommendations in the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain, noting that "When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids." Three days or less will often be sufficient; more than seven days will rarely be needed [Recommendation category A, evidence type 4].

As the AMA notes, this recommendation is based on expert consensus. This recommendation is also supported by a significant body of research that has emerged since the guideline was released, with strong empirical evidence regarding the extent to which additional days' supply increases risk of long-term opioid use, especially the work by Shah et al in the CDC Measles, Mumps, and Rubella (MMR) weekly reports (1), Brat et al (2), Zhang et al (3), among others. For more information, we recommend referring to the measure's evidence attachment.

Regarding the use of a 90-day lookback period, "lookback periods" are variably defined in the current literature, with some studies using 60-days and others up to 12 months. Considering Part D's opioid naïve edits, CMS recommends that Part D sponsors use a lookback period of at least 60 days, with most sponsors using lookback periods between 60 and 120 days (4,5). PQA tested numerous lookback period options, including 30, 45, 90, and 120 days, and discussed this question extensively with subject matter experts and Technical Expert Panels (TEPs). Ultimately, the TEP found the 30-day interval to be oversensitive in identifying prescriptions as initial, and there were inherent tradeoffs between sensitivity and specificity at each of the other lookback periods. Per testing, the overall impact of using different lookback periods was generally minor. As such, the TEP came to consensus that the 90-day lookback period is most appropriate.

Regarding the measure's use of methadone, methadone identified through prescription claims is accurately differentiated from methadone that is indicated as used for medication-assisted treatment of opioid use disorder (OUD), which is restricted to be dispensed only from federally certified opioid treatment programs. As a result, an exclusion for individuals receiving OUD is not required, as the measure only captures methadone prescribed for pain management, and drugs indicated for medication assisted treatment of OUD (e.g., buprenorphine) are not included in the measure. This approach to inclusion of methadone is consistent with other PQA opioid measures implemented in

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

federal programs, and PQA has not received feedback or evidence of unintended consequences related to methadone inclusion in this manner. As IOP-LD is implemented, PQA will continue to monitor for feedback and will evaluate any appropriate changes through our standardized, transparent, and consensus-based maintenance process.

Regarding the AMA's concerns about this measure's use and potential for unintended consequences, PQA would like to emphasize that as a retrospective population-level measure, the measure is not intended to serve as a guide for individual patient care decisions. Although a lower rate indicates better performance, the rate is not expected to be zero, and there are rare situations in which providers may choose to initially prescribe for a greater days' supply for individual patients due to patient individualization considerations. This performance measure is not intended to preclude such situations, but is intended to give a population-level metric for quality, and to establish benchmarks and identify opportunities to decrease initial opioid prescriptions for long duration that may place patients at increased risk for long-term opioid use, misuse, overdose, and other negative outcomes.

1) Shah A, Hayes CJ, Martin BC, et al. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1external icon.
2) Brat GA, Agniel D, Beam A, et al. Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study. BMJ. 2018;360:j5790. Published 2018 Jan 17. doi:10.1136/bmj.j5790
3) Zhang Y, Johnson P, Jeng PJ, et al. First Opioid Prescription and Subsequent High-Risk Opioid Use: a National Study of Privately Insured and Medicare Advantage Adults. J Gen Intern Med. 2018;33(12):2156-2162. doi:10.1007/s11606-018-4628-y
4) Centers for Medicare & Medicaid Services. Contract Year (CY) 2020 Opioid Safety Edit Reminders and Recommendations. Available from https://www.cms.gov/files/document/cy-2020-opioid-safety-edits-reminders-and-recommendations.pdf.
5) Centers for Medicare & Medicaid Services. Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Available from https://www.cms.gov/MEDICARE/HEALTH-PLANS/MEDICAREADVTGSPECRATESTATS/DOWNLOADS/ANNOUNCEMENT2019.PDF.

- Concerns about the inclusion of methadone.

  Measure Steward/Developer Response:
  PQA appreciates the American Society of Health-System Pharmacists (ASHP)'s support of the IOP-LD measure and thoughtfulness on the inclusion of methadone. As ASHP notes, methadone identified through prescription claims can accurately differentiate methadone that is indicated as used for medication-assisted treatment of opioid use disorder (OUD), which is restricted to be dispensed only from federally certified opioid treatment programs. This approach to inclusion of methadone is consistent with other PQA opioid measures implemented in several federal programs, and PQA has not received feedback or evidence of unintended consequences related to methadone inclusion in this manner. As IOP-LD is implemented, PQA will continue to monitor for feedback and will evaluate any appropriate changes through our standardized, transparent, and consensus-based maintenance process.

- Support with concerns about inclusion of long-term care (LTC) settings.

  Measure Steward/Developer Response:

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

PQA appreciates the American Society for Clinical Pathology (ASCP)'s support and feedback on the IOP-LD measure regarding a potential exclusion for individuals in long-term care. PQA considers changes to PQA-endorsed measures through a standardized, transparent, and consensus-based process involving several multistakeholder panels composed of clinical and measurement science experts. The PQA team is currently evaluating the appropriateness and feasibility of adding an exclusion for individuals in long-term care and will consider this potential change through our standardized and robust maintenance process.

- Support with concern for potential abuse.

  Measure Steward/Developer Response:
  PQA appreciates Magellan's support and feedback on the IOP-LD measure regarding interpretation of multiple opioid claims that occur on the same day. The IOP-LD measure's methodology in this case is aligned with other PQA opioid measures and accounts for the fact that multiple opioids may be prescribed to be taken concurrently. In such cases, adding days' supply of multiple opioid claims received on the same day may overestimate the true days' supply. However, the PQA team will take this under advisement for future consideration. PQA considers changes to PQA-endorsed measures through a standardized, transparent, and consensus-based process involving several multistakeholder panels composed of clinical and measurement science experts.

- Concerns about the appropriateness of the measure and evidence criterion being met.

  Measure Steward/Developer Response:
  PQA appreciates the American Geriatrics Society (AGS)' feedback on the IOP-LD measure. PQA considers changes to PQA-endorsed measures through a standardized, transparent, and consensus-based process involving several multistakeholder panels composed of clinical and measurement science experts. As additional exclusions are identified to be potentially appropriate, they will be considered through this robust process.

  The 7-day threshold was chosen based on recommendations in the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain, noting that "When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids." Three days or less will often be sufficient; more than seven days will rarely be needed [Recommendation category A, evidence type 4]. This recommendation has been supported by a significant body of research that has emerged since the guideline was released, with strong empirical evidence regarding the extent to which additional days' supply increases risk of long-term opioid use, especially the work by Shah et al in the CDC MMR weekly reports (1), Brat (2), Zhang (3), among others. For more information, we recommend referring to the measure's evidence attachment.

  Finally, we note that literature such as Zhang et al demonstrates that the risks associated with an initial prescription days' supply exceeding seven days was present in a Medicare Advantage population, further demonstrating that even older Americans face risks associated with initial opioid prescribing at long duration; furthermore, Brat et al demonstrated that these risks are also present in post-surgical patients.

  1) Shah A, Hayes CJ, Martin BC, et al. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1external icon.

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)
2) Brat GA, Agniel D, Beam A, et al. Postsurgical prescriptions for opioid naive patients and association with overdose and misuse: retrospective cohort study. BMJ. 2018;360:j5790. Published 2018 Jan 17. doi:10.1136/bmj.j5790 3) Zhang Y, Johnson P, Jeng PJ, et al. First Opioid Prescription and Subsequent High-Risk Opioid Use: a National Study of Privately Insured and Medicare Advantage Adults. J Gen Intern Med. 2018;33(12):2156-2162. doi:10.1007/s11606-018-4628-y • Inquiry on future CMS implementations of related health plan patient safety edits and opioid management templates. Measure Steward/Developer Response: PQA appreciates Humana's comment in support of the IOP-LD measure. Although the IOP-LD measure is included in the CMS Part D Patient Safety Reports program, the PQA team is not able to provide insight on future CMS implementations of related health plan patient safety edits and opioid management templates. PQA recommends that Humana bring this question to CMS for further clarification.
8. Consensus Standards Approval Committee (CSAC) Vote (July 29, 2020): Y-11; N-0 Decision: Approved for endorsement
9. Appeals No appeals were received

Appendix B: Patient Safety Portfolio—Use in Federal Programs[1]

NQF#	Title	Federal Programs: Finalized or Implemented
0022	Use of High-Risk Medications in the Elderly (DAE)	Merit-Based Incentive Payment System (MIPS) Program (Implemented)
0097	Medication Reconciliation Post-Discharge	Medicare Part C Star Rating (Implemented)
0101	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	Medicare Shared Savings Program (MSSP) (Implemented) MIPS Program (Implemented)
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Hospital Acquired Condition Reduction Program (HACRP) (Implemented) Inpatient Rehabilitation Facility (IRF) Quality Reporting (Implemented) Long-Term Care Hospital (LTCH) Quality Reporting (Implemented) Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (Implemented)
0139	National Healthcare Safety Network (NHSN) Central Line-associated Bloodstream Infection (CLABSI) Outcome Measure	HACRP (Implemented) LTCH Quality Reporting (Implemented) Long-Term Care Hospital (LTCH) Compare (Implemented) PPS-Exempt Cancer Hospital Quality Reporting (Implemented)
0141	Patient Fall Rate	None
0202	Falls with injury	None
0204	Skill mix (Registered Nurse [RN], Licensed Vocational/Practical Nurse [LVN/LPN], unlicensed assistive personnel [UAP], and contract)	None
0205	Nursing Hours per Patient Day	None

[1] Per CMS Measures Inventory Tool as of 01/22/2021

NQF#	Title	Federal Programs: Finalized or Implemented
0206	Practice Environment Scale - Nursing Work Index (PES-NWI) (composite and five subscales)	None
0231	Pneumonia Mortality Rate (IQI #20)	None
0337	Pressure Ulcer Rate (PDI 2)	None
0344	Accidental Puncture or Laceration Rate (PDI #1)	None
0345	Unrecognized Abdominopelvic Accidental Puncture or Laceration Rate (PSI15)	None
0346	Iatrogenic Pneumothorax Rate (PSI 6)	None
0347	Death Rate in Low-Mortality Diagnosis Related Groups (PSI02)	None
0348	Iatrogenic Pneumothorax Rate (PDI 5)	None
0349	Transfusion Reaction Count (PSI 16)	None
0350	Transfusion Reaction Count (PDI 13)	None
0352	Failure to Rescue In-Hospital Mortality (risk adjusted)	None
0353	Failure to Rescue 30-Day Mortality (risk adjusted)	None
0362	Retained Surgical Item or Unretrieved Device Fragment Count (PDI 03)	None
0363	Retained Surgical Item or Unretrieved Device Fragment Count (PSI 05)	None
0419	Documentation of Current Medications in the Medical Record	MIPS Program (Implemented)
0419e	Documentation of Current Medications in the Medical Record	MIPS Program (Implemented) Medicaid Promoting Interoperability Program for Eligible Professionals (Implemented)
0450	Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate (PSI 12)	None
0468	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following pneumonia hospitalization	Hospital Value-Based Purchasing (Implemented)
0500	Severe Sepsis and Septic Shock: Management Bundle	None
0530	Mortality for Selected Conditions	None
0531	Patient Safety and Adverse Events Composite	HACRP (Implemented)
0553	Care for Older Adults (COA) – Medication Review	Medicare Part C Star Rating (Implemented)

NQF#	Title	Federal Programs: Finalized or Implemented
0555	INR Monitoring for Individuals on Warfarin	Marketplace Quality Rating System (Implemented)
0674	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Home Health Quality Reporting (Implemented) LTCH Quality Reporting (Implemented) Skilled Nursing Facility Quality Reporting (Implemented) IRF Quality Reporting (Implemented)
0679	Percent of High-Risk Residents with Pressure Ulcers (Long Stay)	None
0684	Percent of Residents with a Urinary Tract Infection (Long-Stay)	None
0686	Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (long stay)	None
0687	Percent of Residents Who Were Physically Restrained (Long Stay)	None
0689	Percent of Residents Who Lose Too Much Weight (Long-Stay)	None
0753	American College of Surgeons – Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Hospital Value-Based Purchasing (VBP) (Implemented) Hospital Acquired Condition Reduction Program (Implemented) PPS-Exempt Cancer Hospital Quality Reporting (Implemented)
1716	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure	HACRP (Implemented) PPS-Exempt Cancer Hospital Quality Reporting (Implemented)
1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	HACRP (Implemented) IRF Quality Reporting (Implemented) LTCH Quality Reporting (Implemented) PPS-Exempt Cancer Hospital Quality Reporting (Implemented)
1893	Hospital 30-Day, all-cause, risk-standardized mortality rate (RSMR) following chronic obstructive pulmonary disease (COPD) hospitalization	Hospital (VBP) (Implemented)

NQF#	Title	Federal Programs: Finalized or Implemented
2065	Gastrointestinal Hemorrhage Mortality Rate (IQI #18)	None
2456	Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	None
2720	National Healthcare Safety Network (NHSN) Antimicrobial Use Measure	None
2723	Wrong-Patient Retract-and-Reorder (Wrong Patient-RAR) Measure	None
2726	Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections	MIPS Program (Implemented)
2732e	INR Monitoring for Individuals on Warfarin after Hospital Discharge	None
2820	Pediatric Computed Tomography (CT) Radiation Dose	None
2909	Perioperative Hemorrhage or Hematoma Rate (PSI 09)	None
2940	Use of Opioids at High Dosage in Persons Without Cancer	Medicaid (Implemented)
2950	Use of Opioids from Multiple Providers in Persons Without Cancer	None
2951	Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer	None
2988	Medication Reconciliation for Patients Receiving Care at Dialysis Facilities	End-Stage Renal Disease Quality Incentive Program (Finalized)
2993	Potentially Harmful Drug-Disease Interactions in the Elderly	None
3000	PACE-Acquired Pressure Ulcer/Injury Prevalence Rate	None
3001	PACE Participant Fall Rate	None
3003	PACE Participant Falls With Injury Rate	None
3025	Ambulatory Breast Procedure Surgical Site Infection (SSI) Outcome Measure	None
3136	GAPPS: Rate of preventable adverse events per 1,000 patient-days among pediatric inpatients	None
3215	Adult Inpatient Risk Adjusted Sepsis Mortality	None

Appendix C: Patient Safety Standing Committee and NQF Staff

STANDING COMMITTEE

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Appendix D: Measure Specifications

#2723 Wrong-Patient Retract-and-Reorder (Wrong Patient-RAR) Measure

STEWARD

NewYork-Presbyterian Hospital

DESCRIPTION

A Wrong-Patient-RAR event occurs when an order is placed on a patient within an EHR, is retracted within 10 minutes, and then the same clinician places the same order on a different patient within the next 10 minutes. A Wrong-Patient-RAR rate is calculated by dividing Wrong-Patient-RAR events by total orders examined.

TYPE

Process

DATA SOURCE

Electronic Health Data, Electronic Health Records, Other

The data source for the Wrong-Patient RAR measure is a replicate EHR or data warehouse. The *Wrong-Patient-RAR* measure uses an electronic query to retrospectively extract information on all electronic orders placed during a specified time period.

LEVEL

Facility, Integrated Delivery System

SETTING

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

NUMERATOR STATEMENT

Total Wrong-Patient RAR events during a specified time period.

NUMERATOR DETAILS

A Wrong-Patient RAR event occurs when an electronic order, including medications, lab tests, imaging, procedures, and general care orders, is placed on a patient, is retracted within 10 minutes by the same provider, and then the same clinician places the same order on a different patient within the next 10 minutes.

Note 1: Definition of a Retracted Order –an order that is discontinued and never acted upon. For Electronic Medical Records (EMRs) that do not support the “retraction” function, retracted orders can be defined as orders that are “discontinued” or “cancelled,” excluding those in which an action has been charted prior to being discontinued or cancelled.

Note 2: Definition of an Ordering Clinician – for this measure, the ordering clinician is the person who enters the order into the computer. Example 1: if a nurse takes a verbal order from a physician and enters the order into the computer, it is the nurse who may select the wrong patient and is considered the ordering clinician. Example 2: if a medical student enters an order

for a patient that is co-signed by a supervising resident, it is the medical student who may select the wrong patient and is considered the ordering clinician.

Note 3: A "retract-and-reorder" event only qualifies for this measure if it is the very next order entry activity by that clinician after they retract the initial order. In other words, if a clinician places an order for patient A, retracts it within 10 minutes, and before reordering it for patient B, he or she places one or more orders for patient C, this would not qualify as a retract-and-reorder event.

DENOMINATOR STATEMENT

All electronic orders placed during a specified time period.

DENOMINATOR DETAILS

All electronic orders, including medications, lab tests, imaging, procedures, and general care orders placed by ordering clinicians during a specified time period.

EXCLUSIONS

System-generated orders are excluded from the denominator. In some EHR systems, in addition to orders placed by clinicians, some orders are generated automatically by the EHR or other ancillary systems (e.g., the pharmacy system, the lab system, or other "interfaces"). Since these orders are not placed by an ordering clinician, they are not included in the denominator.

EXCLUSION DETAILS

None

RISK ADJUSTMENT

Stratification by risk category/subgroup

STRATIFICATION

Results may be stratified by provider type (e.g., MD, RN, PA, pharmacist, etc.), patient type (e.g., age group, gender, race, ethnicity, etc.), order type (e.g., medications, lab tests, imaging, etc.), or location (e.g., ED, inpatient, outpatient, etc.).

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

Measure Logic for Wrong-Patient Retract-and-Reorder (Wrong-Patient-RAR) Events

Numerator

1. Obtain all orders and retraction of orders for a specified time period. For each order and retraction of an order, capture patient and provider demographic characteristics of interest, as well as order information including date and time of order or retraction, and type of order with order details (e.g. Tylenol 325 mg orally three times per day for seven days).
2. Identify the First Order of a potential Wrong-Patient-RAR event (orders that are retracted within 10 minutes of being placed by the same clinician).
3. Identify the Second Order of a potential Wrong-Patient-RAR event. Get the next non-retracted order that was placed within 10 minutes of the above, the similar retracted order by

the same clinician on a different patient. The order should be the same general order, but the underlying details do not need to be an exact match (e.g., dose can change as a computer may adjust dose based on patient weight).

4. Any order that meets the above criteria is a Wrong-Patient-RAR event. Each RAR event involves a single ordering clinician and two different patients.

Denominator

1. Obtain all orders examined in the specified time period. For each order, capture patient and provider demographic characteristics of interest as well as order information, including date and time of order and type of order with order details.

Rate Calculation (per 100,000 orders)

1. For a specified time period, the Wrong-Patient-RAR Rate is calculated as total Wrong-Patient RAR Events divided by total orders multiplied by 100,000.

(Total Wrong-Patient RAR Events/Total Orders) ? 100,000

2. The Wrong-Patient RAR Rate can be stratified by subgroups of interest. 123738| 150991| 147926| 141015| 150289

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None

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

STEWARD

Pharmacy Quality Alliance

DESCRIPTION

The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.

TYPE

Process

DATA SOURCE

Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); enrollment data

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.

NUMERATOR DETAILS

The number of individuals from the denominator with greater than sevengreater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

Use the steps below to identify the numerator population:

Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days.

For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17.

Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 3: Count the unique individuals with greater than sevengreater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.

DENOMINATOR STATEMENT

The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

DENOMINATOR DETAILS

The denominator includes individuals aged18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication andcontinuous enrollment during that time and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period.

Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure.

Complete the steps below to determine the denominator population.

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice

• Cancer

• Sickle cell disease

Medication Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

EXCLUSIONS

Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

EXCLUSION DETAILS

Hospice exclusion: Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Use the following to identify individuals in hospice:

•Hospice indicator from the enrollment database, if available (e.g. Medicare)

•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid)

Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.

•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See Pharmayc Quality Alliance ICD Code Value Sets, Cancer tab.

•Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

Exclude any individuals having one or more claims with sickle cell disease in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

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 government to the drug plan for Medicae beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

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

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

A. Target population (denominator):

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

- Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using:
  - Hospice indicator from the enrollment database, if available (e.g. Medicare); or
  - One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid)
- Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using:
  - One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.
  - Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).
- Identify individuals having one or more claims with SCD in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.

B. Numerator Population:

Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods.

Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + 2 days).

For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17.

NOTE:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.
- If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 9: Count the unique individuals with greater than seven greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator.

C. Measure Rate:

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

- Note: Report the rates separately by line of business (e.g. Medicare, Medicaid, commercial). For Medicare, report rates for LIS and non-LIS populations separately. 135614

Appendix E1: Related and Competing Measures (tabular format)

Comparison of NQF #3558 and NQF #2940

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
Steward	Pharmacy Quality Alliance	Pharmacy Quality Alliance
Description	The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions forgreater than sevencumulative days' supply.	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents (MME) over a period of greater than or equal to 90 days. A lower rate indicates better performance.
Type	Process	Process
Data Source	Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx	Claims, Electronic Health Data, Enrollment Data Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment Cancer_Exclusion_Codes.xlsx
Level	Health Plan	Health Plan, Other, Population : Regional and State
Setting	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.
Numerator Statement	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the 3-day time period when the numerator is assessed.	The numerator includes individuals from the denominator with an average daily dosage greater than or equal to 90 MME during the opioid episode.
Numerator Details	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. Use the steps below to identify the numerator population:	The numerator includes individuals from the denominator with an average daily dosage greater than or equal to 90 MME during the opioid episode.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days. For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17. Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day. Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.	1. For each individual in the denominator population, identify all opioid prescription claims (Table Opioid-A) during the opioid episode. 2. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor. The strength and MME conversion factor are provided for each NDC code in the NDC file. Examples: 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day 25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day 3. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1). NOTE: • If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim. • Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode. 4. For each individual, sum the MMEs across all days during the opioid episode. 5. Calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98). 6. Count the individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode. Table Opioid-A: Opioid Medications (MME conversion factor)

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
		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: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.
Denominator Statement	The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.	Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.
Denominator Details	The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the	Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period. Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure. Complete the steps below to determine the denominator population. Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.	15 during the measurement year. Individuals with cancer or in hospice are excluded. 1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year. 2. 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). 3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. 4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year. 5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year. NOTE: • The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first. Table Opioid-A: Opioid Medications butorphanol

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Hospice • Cancer • Sickle cell disease Medication Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough andcold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)	codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol *Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.
Exclusions	Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.	Exclude individuals who met at least one of the following during the measurement year: • Hospice • Cancer diagnosis
Exclusion Details	Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them: •Hospice indicator from the enrollment database, if available (e.g. Medicare)	Any individual in hospice during the measurement year. • Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or • Use place of service code 34 or type of service code 35 where a hospice indicator is not available (e.g. commercial, Medicaid).

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid) Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. •One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. •Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). Sickle cell exclusion: Exclude any individuals having one or more claims with SCD in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.	Any individual with a cancer diagnosis during the measurement year. • See PQA ICD Code Value Sets, Cancer Exclusion • 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. • Medicare Data (if ICD codes note available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2017 or 2018.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	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-IncomeLIS)-A subsidy paid by the federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.	Commercial, Medicaid, Medicare (report each product line separately). LIS population (report rates for LIS population and non-LIS population separately.

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	The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score
Algorithm	A. Target population (denominator): Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids.	DENOMINATOR 1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year. 2. Identify individuals meeting the continuous enrollment criteria. 3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. 4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year. 5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year. NOTE:

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	• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using: o Hospice indicator from the enrollment database, if available (e.g. Medicare); or o One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid) • Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using: o One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. o Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available(available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). • Sickle Cell Disease: Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any	• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first. 6. Exclude individuals who met at least one of the following during the measurement year: • Hospice • Cancer diagnosis This is the denominator population. NUMERATOR 7. For each individual in the denominator population, identify all opioid prescription claims (Table Opioid-A) during the opioid episode. 8. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor. The strength and MME conversion factor are provided for each NDC code in the NDC file. Examples: 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day 25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day 9. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1). NOTE: • If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim. • Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab. Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.) Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator. B. Numerator Population: Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods. Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + 2 days). For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.	10. For each individual, sum the MMEs across all days during the opioid episode. 11. Calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98). 12. Count the individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode. This is the numerator population. MEASURE RATE 13. Divide the numerator by the denominator and multiply by 100. This is the measure rate. Table Opioid-A: Opioid Medications (MME conversion factor) 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)

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncatedto the last day. Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator. C. Measure rate: Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage. • Note: 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.	tramadol (0.1) *Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.
Submission items	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 #3389 Concurrent Use of Opioids and Benzodiazepines (COB) #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended	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

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2940: Use of Opioids at High Dosage in Persons Without Cancer
	for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).	

Comparison of NQF #3558 and NQF #2950

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
Steward	Pharmacy Quality Alliance	Pharmacy Quality Alliance
Description	The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids from greater than or equal to four prescribers AND greater than or equal to four pharmacies within less than or equal to 180 days. A lower rate indicates better performance.
Type	Process	Process
Data Source	Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx	Claims, Electronic Health Data, Enrollment Data Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment Cancer_Exclusion_Codes-637267041490070087.xlsx
Level	Health Plan	Health Plan, Other, Population : Regional and State

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
Setting	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.
Numerator Statement	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.	Individuals from the denominator with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies within less than or equal to 180 days during the opioid episode.
Numerator Details	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. Use the steps below to identify the numerator population: Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days. For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17. Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.	1. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode. Each date of service for greater than or equal to one opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode. 2. For each individual, starting with each unique date of service (for greater than or equal to one opioid prescriptions), identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. 3. For each individual, starting with each unique date of service (for greater than or equal to one opioid prescriptions), identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. 4. Count the unique number of individuals with any numerator evaluation periods with opioid prescription claims from greater than or equal to fourprescribers AND greater than or equal to four pharmacies during the opioid episode. Table Opioid-A: Opioid Medications butorphanol codeine

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncatedto the last day. Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.	dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol *Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.
Denominator Statement	The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.	Individuals 18 years and older with greater than or equal to twoprescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.
Denominator Details	The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period. Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those	1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year. 2. Identify individuals meeting the continuous enrollment criteria. 3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure. Complete the steps below to determine the denominator population. Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3 -July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).	NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. 4. Identify individuals with an index prescription start date (IPSD) from January 1 – October 3 of the measurement year. 5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year. NOTE: • The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first. Table Opioid-A: Opioid Medications butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Hospice • Cancer • Sickle cell disease Medication Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)	tramadol *Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.
Exclusions	Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.	Exclude individuals who met at least one of the following during the measurement year: • Hospice • Cancer diagnosis
Exclusion Details	Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them: •Hospice indicator from the enrollment database, if available (e.g. Medicare) •One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid) Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.	Any individual in hospice during the measurement year. • Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or • Use place of service code 34 or type of service code 35 where a hospice indicator is not available (e.g. commercial, Medicaid). Cancer Diagnosis Exclusion: Any individual with a cancer diagnosis during the measurement year. • See PQA ICD Code Value Sets, Cancer Exclusion • 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.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. •Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). Sickle cell exclusion: Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.	• Medicare Data (if ICD codes note available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2017 or 2018.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D	Commercial, Medicaid, Medicare (report each product line separately). Low income subsidy (LIS) population (report rates for LIS population and non-LIS population separately).

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score
Algorithm	A. Target population (denominator): Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.	DENOMINATOR 1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year. 2. Identify individuals meeting the continuous enrollment criteria. 3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. 4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year. 5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year. NOTE: • The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first. 6. Exclude individuals who met at least one of the following during the measurement year:

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using: o Hospice indicator from the enrollment database, if available (e.g. Medicare); or o One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid) • Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using: o One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. o Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). • Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab. Table OPIOIDS: Opioids	• Hospice • Cancer diagnosis This is the denominator population. NUMERATOR 7. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode. Each date of service for greater than or equal to 1 opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode. 8. For each individual, starting with each unique date of service (for greater than or equal to oneopioid prescriptions), identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. 9. For each individual, starting with each unique date of service (for greater than or equal to oneopioid prescriptions), identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. 10. Count the unique number of individuals with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode. This is the numerator population. MEASURE RATE 11. Divide the numerator by the denominator and multiply by 100. This is the measure rate. Table Opioid-A: Opioid Medications butorphanol codeine dihydrocodeine fentanyl

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.) Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator. B. Numerator Population: Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods. Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days). For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.	hydrocodone hydromorphone levorphanol meperidine methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day. Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator. C. Measure Rate: Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage. • Note: 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: #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 #3389 Concurrent Use of Opioids and Benzodiazepines (COB) #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, #and 3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related	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

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2950: Use of Opioids from Multiple Providers in Persons Without Cancer
	denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).	

Comparison of NQF #3558 and NQF #2951

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Steward	Pharmacy Quality Alliance	Pharmacy Quality Alliance
Description	The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.	The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from greater than or equal to four prescribers AND greater than or equal to four pharmacies. A lower rate indicates better performance.
Type	Process	Process
Data Source	Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx	Claims, Electronic Health Data, Enrollment Data Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information. No data collection instrument provided Attachment Cancer_Exclusion_Codes-637267044680747732.xlsx
Level	Health Plan	Health Plan, Other, Population : Regional and State

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
Setting	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.
Numerator Statement	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the 3-day time period when the numerator is assessed.	Individuals from the denominator with an average daily dosage greater than or equal to 90 MME during the opioid episode AND with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies within less than or equal to 180 days during the opioid episode.
Numerator Details	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. Use the steps below to identify the numerator population: Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days. For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17. Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.	1. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode. 2. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor. The strength and MME conversion factor are provided for each NDC code in the NDC file. Examples: 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day 25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day 3. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1). NOTE: • If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim. • Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	• If the opioid initiation period extends beyond the end of the measurement year, itis truncated to the last day . Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.	4. For each individual, sum the MMEs across all days during the opioid episode. 5. For each individual, calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98). 6. Identify individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode. 7. For each individual identified in step 6, starting with each unique date of service (for greater than or equal to 1 opioid prescriptions) within the opioid episode, identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. Each date of service for greater than or equal to 1 opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode. 8. For each individual in step 7, starting with each unique date of service (for greater than or equal to one opioid prescriptions) within the opioid episode, identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. 9. Count the individuals from step 8 with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode. Table Opioid-A: Opioid Medications (MME conversion factor) butorphanol (7) codeine (0.15) dihydrocodeine (0.25)

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
		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)
Denominator Statement	The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.	Individuals 18 years and older with greater than or equal to twoprescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.
Denominator Details	The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period. Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the	Individuals 18 years and older with greater than or equal to 2 prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded. 1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year. 2. 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

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure. Complete the steps below to determine the denominator population. Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).	have more than a one-month gap in coverage (i.e., an individual whose coverage lapses for two months [60 days] is not considered continuously enrolled). 3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. 4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year. 5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year. NOTE: • The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first. Table Opioid-A: Opioid Medications butorphanol codeine dihydrocodeine fentanyl hydrocodone hydromorphone levorphanol meperidine

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Hospice • Cancer • Sickle Cell Disease Medication Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)	methadone morphine opium oxycodone oxymorphone pentazocine tapentadol tramadol *Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.
Exclusions	Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.	Exclude individuals who met at least one of the following during the measurement year: • Hospice • Cancer diagnosis
Exclusion Details	Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them: •Hospice indicator from the enrollment database, if available (e.g. Medicare) •One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid) Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.	Any individual in hospice during the measurement year. • Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or • Use place of service code 34 or type of service code 35 where a hospice indicator is not available (e.g. commercial, Medicaid). Any individual with a cancer diagnosis during the measurement year. • See PQA ICD Code Value Sets, Cancer Exclusion • 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.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. •Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.	• Medicare Data (if ICD codes note available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2017 or 2018.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D	Commercial, Medicaid, Medicare (report each product line separately). Low-income subsidy (LIS) population (report rates for LIS population and non-LIS population separately.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score
Algorithm	A. Target population (denominator): Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.	DENOMINATOR 1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year. 2. Identify individuals meeting the continuous enrollment criteria. 3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. 4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year. 5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year. NOTE: • The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first. 6. Exclude individuals who met at least one of the following during the measurement year:

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Hospice: Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using: o Hospice indicator from the enrollment database, if available (e.g. Medicare); or o One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid) • Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using: o One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. o Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). • Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab. Table OPIOIDS: Opioids	• Hospice • Cancer diagnosis This is the denominator population. NUMERATOR 7. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode. 8. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor. The strength and MME conversion factor are provided for each NDC code in the NDC file. Examples: 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day 25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day 9. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1). NOTE: • If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim. • Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode. 10. For each individual, sum the MMEs across all days during the opioid episode. 11. For each individual, calculate the average MME across all days during the opioid episode. The average daily MME = total

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.) Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator. B. Numerator Population: Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods. Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days). For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.	MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98). 12. Identify individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode. 13. For each individual identified in step 12, starting with each unique date of service (for greater than or equal to one opioid prescriptions) within the opioid episode, identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. Each date of service for greater than or equal to one opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode. 14. For each individual in step 13, starting with each unique date of service (for greater than or equal to one opioid prescriptions) within the opioid episode, identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter. 15. Count the individuals from step 14 with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode. This is the numerator population. MEASURE RATE 16. Divide the numerator by the denominator and multiply by 100. This is the measure rate. Table Opioid-A: Opioid Medications (MME conversion factor) butorphanol (7) codeine (0.15) dihydrocodeine (0.25) fentanyl buccal or SL tablets, or lozenze/troche (0.13)

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day. Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator. C. Measure Rate: Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage. • Note: 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.	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)
Submission items	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 #3389 Concurrent Use of Opioids and Benzodiazepines (COB) #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid	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

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	2951: Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer
	prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).	

Comparison of NQF #3558 and NQF # 3389

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
Steward	Pharmacy Quality Alliance	PQA, Inc.
Description	The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.	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
Data Source	Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.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
Level	Health Plan	Health Plan

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
Setting	Outpatient Services	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	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.	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	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. Use the steps below to identify the numerator population: Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days. For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17. Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period..	The number of individuals from the denominator with: • Two 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 two 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.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.	Note: When identifying days' supply for opioids (or benzodiazepines), do the following: • Exclude any days' supply that occur after the end of the measurement year. • 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	The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.	The denominator includes individuals 18 years and older with two 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 denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period. Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure. Complete the steps below to determine the denominator population. Step 1: Identify individuals 18 years or older as of the first day of the measurement year.	The denominator includes individuals 18 years and older by the first day of the measurement year with two 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 one-month gap in coverage (i.e., an individual whose coverage lapses for two months [60 days] is not considered continuously enrolled).

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Hospice • Cancer • Sickle cdell isease Medication Table OPIOIDS: Opioids	Step 3: Of those identified in step 2, identify individuals with two 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, do the following: • Exclude any days' supply that occur after the end of the measurement year. • 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).

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)	
Exclusions	Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.	Individuals with cancer or in hospice at any point during the measurement year are excluded from the denominator.
Exclusion Details	Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them: •Hospice indicator from the enrollment database, if available (e.g. Medicare) •One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid) Cancer exclusion: Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. •One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. •Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).	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. Use the following 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:

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	Sickle cell exclusion: Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.	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
Stratification	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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	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. LIS is a subsidy paid by the federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for LIS with the Social Security Administration or their state Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify LIS status, which is subsidized Part D coverage. There are 12 monthly variables where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score
Algorithm	A. Target population (denominator): Step 1: Identify individuals 18 years or older as of the first day of the measurement year.	A. Target population (denominator): Step 1: Identify individuals aged 18 years and older as of the first day of the measurement year

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • ndividuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using: o Hospice indicator from the enrollment database, if available (e.g. Medicare); or	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 one-month gap in coverage (i.e., an individual whose coverage lapses for two months [60 days] is not considered continuously enrolled). Step 3: Of those identified in step 2, identify individuals with two 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, do the following: • Exclude any days' supply that occur after the end of the measurement year. • 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. Use the following 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) Use the following 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:

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	o One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid) • Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using: o One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. o Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). • Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab. Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.) Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.	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 two 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), do the following: • Exclude any days' supply that occur after the end of the measurement year. • For multiple prescription claims for opioids (or benzodiazepines) with overlapping days' supply, count each day in

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
	B. Numerator Population: Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods. Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days). For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day. Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator. C. Measure Rate: Step 10: Divide the number of individuals in the numerator (Step 9) by the denominator (Step 6) and multiply by 100. This is the measure rate reported as a percentage. • Note: Report the rates separately by line of business (e.g. Medicare, Medicaid, Commercial). For Medicare, report rates for LIS and non-LIS populations separately.	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.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3389: Concurrent Use of Opioids and Benzodiazepines (COB)
Submission items	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 #3389 Concurrent Use of Opioids and Benzodiazepines (COB) #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure. 5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).	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 (#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).

Comparison of NQF #3558 and NQF # 3541

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Steward	Pharmacy Quality Alliance	Pharmacy Quality Alliance
Description	The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.	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	Process
Data Source	Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx	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

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
		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
Level	Health Plan	Health Plan
Setting	Outpatient Services	Outpatient Services
Numerator Statement	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the 3-day time period when the numerator is assessed.	Individuals in the denominator population who have not received a drug test during the measurement year.
Numerator Details	The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period. Use the steps below to identify the numerator population: Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods defined as the date of service of the initial opioid prescription plus two days. For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17. Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period. NOTE: • The prescription can be for the same or different opioids.	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."

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.. Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.	
Denominator Statement	The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.	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 denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period. Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure. Complete the steps below to determine the denominator population. Step 1: Identify individuals 18 years or older as of the first day of the measurement year.	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 must fit the following qualifications: 1) 18 years of age and older as of the first day of the measurement year.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3 -July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year: • Hospice • Cancer • Sickle cell disease	2) 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.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	Medication Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)	
Exclusions	Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.	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	Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them: •Hospice indicator from the enrollment database, if available (e.g. Medicare) •One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid) Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. •One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. •Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (afrom https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).	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,

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.	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	No risk adjustment or risk stratification
Stratification	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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency. The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.	Not applicable.
Type Score	Rate/proportion better quality = lower score	Rate/proportion better quality = lower score

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
Algorithm	A. Target population (denominator): Step 1: Identify individuals 18 years or older as of the first day of the measurement year. Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year. Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD. Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period. For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator). Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:	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:

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	• Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using: o Hospice indicator from the enrollment database, if available (e.g. Medicare); or o One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid) • Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using: o One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab. o Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html). • Sickle cell disease: Identify individuals having one or more claims with sickle cell disease in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab. Table OPIOIDS: Opioids Benzhydrocodone, butorphanol, codeine, dihydrocodeine, fentanyl, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, opium, oxycodone, oxymorphone, pentazocine, tapentadol, tramadol (Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine	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.

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.) Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator. B. Numerator Population: Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods. Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days). For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day. Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator. C. Measure Rate:	

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	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. • Note: 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: #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 #3389 Concurrent Use of Opioids and Benzodiazepines (COB) #3541 Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure.	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, #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

	3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)
	5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).	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.

Appendix E2: Related and Competing Measures (narrative format)

Comparison of NQF #3558 and NQF #2940

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)
#2940 Use of Opioids at High Dosage in Persons Without Cancer

Steward

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Pharmacy Quality Alliance

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

Pharmacy Quality Alliance

Description

3558: Initial Opioid Prescribing for Long Duration (IOP-LD)

The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.

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

The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents (MME) over a period of greater than or equal to 90 days.

A lower rate indicates better performance.

Type

3558: Initial Opioid Prescribing for Long Duration (IOP-LD)

Process

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

Process

Data Source

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data

No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx

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

Claims, Electronic Health Data, Enrollment Data Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment Cancer_Exclusion_Codes.xlsx

Level

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Health Plan

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

Health Plan, Other, Population : Regional and State

Setting

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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.

Numerator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the 3-day time period when the numerator is assessed.

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

The numerator includes individuals from the denominator with an average daily dosage greater than or equal to 90 MME during the opioid episode.

Numerator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

Use the steps below to identify the numerator population:

Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days.

For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17.

Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.

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

The numerator includes individuals from the denominator with an average daily dosage greater than or equal to 90 MME during the opioid episode.

1. For each individual in the denominator population, identify all opioid prescription claims (Table Opioid-A) during the opioid episode.

2. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor. The strength and MME conversion factor are provided for each NDC code in the NDC file.

Examples:

10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day

25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day

3. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1).

NOTE:

• If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.

• Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode.

4. For each individual, sum the MMEs across all days during the opioid episode.

5. Calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98).

6. Count the individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode.

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

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: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Denominator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

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

Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.

Denominator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period.

Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure.

Complete the steps below to determine the denominator population.

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice

• Cancer

• Sickle cell disease

Medication Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

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

Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.

1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year.

2. 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 two months [60 days] is not considered continuously enrolled).

3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year.

5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year.

NOTE:

• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first.

Table Opioid-A: Opioid Medications

butorphanol

codeine

dihydrocodeine

fentanyl

hydrocodone

hydromorphone
levorphanol
meperidine
methadone
morphine
opium
oxycodone
oxymorphone
pentazocine
tapentadol
tramadol

*Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Exclusions

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

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

Exclude individuals who met at least one of the following during the measurement year:

• Hospice
• Cancer diagnosis

Exclusion Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement yea, using the following to identify them:

•Hospice indicator from the enrollment database, if available (e.g. Medicare)

•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)

Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.

•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.

•Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

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

Any individual in hospice during the measurement year.

• Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or

• Use place of service code 34 or type of service code 35 where a hospice indicator is not available (e.g. Commercial, Medicaid).

Cancer Diagnosis Exclusion: Any individual with a cancer diagnosis during the measurement year.

• See PQA ICD Code Value Sets, Cancer Exclusion

• 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.

• Medicare Data (if ICD codes note available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2017 or 2018.

Risk Adjustment

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

Stratification

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

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

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

Commercial, Medicaid, Medicare (report each product line separately). Low income subsidy (LIS) population (report rates for LIS population and non-LIS population separately.

Type Score

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Rate/proportion better quality = lower score

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

Rate/proportion better quality = lower score

Algorithm

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

A. Target population (denominator):

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

- Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using:
    - Hospice indicator from the enrollment database, if available (e.g. Medicare); or
    - One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)
- Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using:
    - One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.
    - Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

- Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.

B. Numerator Population:

Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods.

Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days).

For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17.

NOTE:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.
- If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator.

C. Measure Rate:

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

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

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

DENOMINATOR

1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year.

2. Identify individuals meeting the continuous enrollment criteria.

3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year.

5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year.

NOTE:

• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first.

6. Exclude individuals who met at least one of the following during the measurement year:

• Hospice

• Cancer Diagnosis

This is the denominator population.

NUMERATOR

7. For each individual in the denominator population, identify all opioid prescription claims (Table Opioid-A) during the opioid episode.

8. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor. The strength and MME conversion factor are provided for each NDC code in the NDC file.

Examples:

10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day

25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day

9. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1).

NOTE:

• If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.

• Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode.

10. For each individual, sum the MMEs across all days during the opioid episode.

11. Calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98).

12. Count the individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode. This is the numerator population.

MEASURE RATE

13. Divide the numerator by the denominator and multiply by 100. This is the measure rate.

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

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: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Submission items

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).

#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

Comparison of NQF #3558 and NQF #2950

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)
#2950 Use of Opioids from Multiple Providers in Persons Without Cancer

Steward

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Pharmacy Quality Alliance

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

Pharmacy Quality Alliance

Description

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.

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

The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids from greater than or equal to four prescribers AND greater than or equal to four pharmacies within less than or equal to 180 days.

A lower rate indicates better performance.

Type

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Process

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

Process

Data Source

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data

No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx

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

Claims, Electronic Health Data, Enrollment Data Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment Cancer_Exclusion_Codes-637267041490070087.xlsx

Level

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Health Plan

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

Health Plan, Other, Population : Regional and State

Setting

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Outpatient Services

#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.

Numerator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.

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

Individuals from the denominator with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies within less than or equal to 180 days during the opioid episode.

Numerator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

Use the steps below to identify the numerator population:

Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days.

For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17.

Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.

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

1. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode.

Each date of service for greater than or equal to 1 opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode.

2. For each individual, starting with each unique date of service (for greater than or equal to 1 opioid prescriptions), identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter.

3. For each individual, starting with each unique date of service (for greater than or equal to one opioid prescriptions), identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter.

4. Count the unique number of individuals with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode.

Table Opioid-A: Opioid Medications

butorphanol

codeine

dihydrocodeine

fentanyl

hydrocodone

hydromorphone

levorphanol

meperidine

methadone

morphine

opium

oxycodone

oxymorphone

pentazocine

tapentadol

tramadol

*Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Denominator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

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

Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.

Denominator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period.

Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure.

Complete the steps below to determine the denominator population.

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice

• Cancer

• Sickle cell disease

Medication Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

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

1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year.

2. Identify individuals meeting the continuous enrollment criteria.

3. Identify individuals with greater than or equal to 2 prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year.

5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year.

NOTE:

• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first.

Table Opioid-A: Opioid Medications

butorphanol

codeine

dihydrocodeine

fentanyl

hydrocodone

hydromorphone

levorphanol

meperidine

methadone

morphine

opium

oxycodone

oxymorphone

pentazocine

tapentadol

tramadol

*Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Exclusions

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

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

Exclude individuals who met at least one of the following during the measurement year:

- Hospice
- Cancer diagnosis

Exclusion Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them:

•Hospice indicator from the enrollment database, if available (e.g. Medicare)

•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)

Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.

•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.

•Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

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

Any individual in hospice during the measurement year.

• Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or

• Use place of service code 34 or type of service code 35 where a hospice indicator is not available (e.g. commercial, Medicaid).

Any individual with a cancer diagnosis during the measurement year.

• See PQA ICD Code Value Sets, Cancer Exclusion

• 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.

• Medicare Data (if ICD codes note available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2017 or 2018.

Risk Adjustment

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

Stratification

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables - where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do

not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

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

Commercial, Medicaid, Medicare (report each product line separately). Low income subsidy (LIS) population (report rates for LIS population and non-LIS population separately.)

Type Score

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Rate/proportion better quality = lower score

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

Rate/proportion better quality = lower score

Algorithm

#3558: Initial Opioid Prescribing for Long Duration (IOP-LD)

A. Target population (denominator):

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using:

  - Hospice indicator from the enrollment database, if available (e.g. Medicare); or
  - One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)

• Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using:

  - One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.
  - Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

• Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.

B. Numerator Population:

Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods.

Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days).

For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17.

NOTE:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.
- If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator.

C. Measure Rate:

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

- Note: 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.

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

DENOMINATOR

1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year.

2. Identify individuals meeting the continuous enrollment criteria.

3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

NOTE:

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

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year.

5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year.

NOTE:

• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first.

6. Exclude individuals who met at least one of the following during the measurement year:

• Hospice

• Cancer diagnosis

This is the denominator population.

NUMERATOR

7. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode.

Each date of service for greater than or equal to one opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode.

8. For each individual, starting with each unique date of service (for greater than or equal to one opioid prescriptions), identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter.

9. For each individual, starting with each unique date of service (for greater than or equal to one opioid prescriptions), identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter.

10. Count the unique number of individuals with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode. This is the numerator population.

MEASURE RATE

11. Divide the numerator by the denominator and multiply by 100. This is the measure rate.

Table Opioid-A: Opioid Medications

butorphanol

codeine

dihydrocodeine
fentanyl
hydrocodone
hydromorphone
levorphanol
meperidine
methadone
morphine
opium
oxycodone
oxymorphone
pentazocine
tapentadol
tramadol

Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Submission items

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid

prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).

#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

Comparison of NQF #3558 and NQF #2951

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

Steward

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Pharmacy Quality Alliance

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

Pharmacy Quality Alliance

Description

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.

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

The percentage of individuals greater than or equal to 18 years of age who received prescriptions for opioids with an average daily dosage of greater than or equal to 90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from greater than or equal to four prescribers AND greater than or equal to four pharmacies.

A lower rate indicates better performance.

Type

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Process

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

Process

Data Source

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data

No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx

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

Claims, Electronic Health Data, Enrollment Data Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.

No data collection instrument provided Attachment Cancer_Exclusion_Codes-637267044680747732.xlsx

Level

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Health Plan

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

Health Plan, Other, Population : Regional and State

Setting

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Outpatient Services

#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.

Numerator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.

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

Individuals from the denominator with an average daily dosage greater than or equal to 90 MME during the opioid episode AND with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies within less than or equal to 180 days during the opioid episode.

Numerator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

Use the steps below to identify the numerator population:

Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days.

For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17.

Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.

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

1. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode.

2. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor.

The strength and MME conversion factor are provided for each NDC code in the NDC file.

Examples:

10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day

25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day

3. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1).

NOTE:

• If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.

• Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode.

4. For each individual, sum the MMEs across all days during the opioid episode.

5. For each individual, calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98).

6. Identify individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode.

7. For each individual identified in step 6, starting with each unique date of service (for greater than or equal to 1 opioid prescriptions) within the opioid episode, identify the number of unique prescribers by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter.

Each date of service for greater than or equal to 1 opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to 180 days during the opioid episode.

8. For each individual in step 7, starting with each unique date of service (for greater than or equal to one opioid prescriptions) within the opioid episode, identify the number of unique pharmacies by NPI occurring within less than or equal to 180 days or through the end of the opioid episode, whichever is shorter.

9. Count the individuals from step 8 with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode.

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

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)

Denominator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

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

Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.

Denominator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period.

Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure.

Complete the steps below to determine the denominator population.

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3 - July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice

• Cancer

• Sickle cell disease

Medication Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

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

Individuals 18 years and older with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Individuals with cancer or in hospice are excluded.

1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year.

2. 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 one-month gap in coverage (i.e., an individual whose coverage lapses for twomonths [60 days] is not considered continuously enrolled).

3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year.

5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year.

NOTE:

• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first.

Table Opioid-A: Opioid Medications

butorphanol

codeine

dihydrocodeine

fentanyl

hydrocodone

hydromorphone

levorphanol

meperidine

methadone

morphine

opium

oxycodone

oxymorphone

pentazocine

tapentadol

tramadol

*Note: Excludes injectable formulations and opioid cough and cold products. Excludes all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.

Exclusions

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

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

Exclude individuals who met at least one of the following during the measurement year:

• Hospice

• Cancer diagnosis

Exclusion Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them:

•Hospice indicator from the enrollment database, if available (e.g. Medicare)

•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid)

Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.

•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.

•Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

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

Any individual in hospice during the measurement year.

• Use the hospice indicator from the enrollment database, where available (e.g. Medicare); or

• Use place of service code 34 or type of service code 35 where a hospice indicator is not available (e.g. commercial, Medicaid).

Any individual with a cancer diagnosis during the measurement year.

• See PQA ICD Code Value Sets, Cancer Exclusion

• 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.

• Medicare Data (if ICD codes note available): RxHCCs 15, 16, 17, 18, 19 for Payment Year 2017 or 2018.

Risk Adjustment

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

Stratification

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

The Medicare Master Beneficiary Summary file contains the Cost Share Group variable used to identify Low-Income Subsidy status, which is subsidized Part D coverage. There are 12 monthly variables where the 01 through 12 at the end of the variable name corresponds with the month (e.g., 01 is January and 12 is December). CMS identifies beneficiaries with fully subsidized Part D coverage by looking for individuals that have a 01, 02, or 03 for the month. Other beneficiaries who are eligible for the LIS but do

not receive a full subsidy have a 04, 05, 06, 07, or 08. The remaining values indicate that the individual is not eligible for subsidized Part D coverage.

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

Commercial, Medicaid, Medicare (report each product line separately). Low income subsidy (LIS) population (report rates for LIS population and non-LIS population separately.

Type Score

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

Algorithm

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

A. Target population (denominator):

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3 - July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

- Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using:
    - Hospice indicator from the enrollment database, if available (e.g. Medicare); or
    - One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)
- Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using:
    - One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.
    - Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).
- Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.

B. Numerator Population:

Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods.

Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days).

For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17.

NOTE:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.
- If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator.

C. Measure Rate:

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

- Note: 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.

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

DENOMINATOR

1. Identify individuals aged greater than or equal to 18 years as of the first day of the measurement year.

2. Identify individuals meeting the continuous enrollment criteria.

3. Identify individuals with greater than or equal to two prescription claims for opioid medications on different dates of service and with a cumulative days' supply greater than or equal to 15 during the measurement year. Exclude days' supply that occur after the end of the measurement year.

NOTE:

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

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

4. Identify individuals with an index prescription start date (IPSD) from January 1-October 3 of the measurement year.

5. Identify individuals with an opioid episode greater than or equal to 90 days during the measurement year.

NOTE:

• The opioid episode start date is the IPSD; the opioid episode end date is the maximum of the date of service + days' supply - 1, or the end of the measurement year, whichever occurs first.

6. Exclude individuals who met at least one of the following during the measurement year:

• Hospice

• Cancer diagnosis

This is the denominator population.

NUMERATOR

7. For each individual in the denominator population, identify all opioid prescription claims during the opioid episode.

8. Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation: [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor.

The strength and MME conversion factor are provided for each NDC code in the NDC file.

Examples:

10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/day

25 µg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/day

9. Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1).

NOTE:

• If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.

• Apply the MME through to the last day of the opioid episode, i.e., do not include days that extend beyond the end of the opioid episode.

10. For each individual, sum the MMEs across all days during the opioid episode.

11. For each individual, calculate the average MME across all days during the opioid episode. The average daily MME = total MME/days in opioid episode. Calculate the average daily MME to 2 decimal places (e.g. 89.98).

12. Identify individuals with an average daily dosage greater than or equal to 90.00 MME during the opioid episode.

13. For each individual identified in step 12, starting with each unique date of service (for greater than or equal to one opioid prescriptions) within the opioid episode, identify the number of unique prescribers by NPI occurring within less than or equal to180 days or through the end of the opioid episode, whichever is shorter.

Each date of service for greater than or equal to 1 opioid prescription claims represents the beginning of a numerator evaluation period of less than or equal to180 days during the opioid episode.

14. For each individual in step 13, starting with each unique date of service (for greater than or equal to one opioid prescriptions) within the opioid episode, identify the number of unique pharmacies by NPI occurring within less than or equal to180 days or through the end of the opioid episode, whichever is shorter.

15. Count the individuals from step 14 with any numerator evaluation periods with opioid prescription claims from greater than or equal to four prescribers AND greater than or equal to four pharmacies during the opioid episode. This is the numerator population.

MEASURE RATE

16. Divide the numerator by the denominator and multiply by 100. This is the measure rate.

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

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)

Submission items

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).

#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

Comparison of NQF #3558 and NQF # 3389

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)
#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Steward

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Pharmacy Quality Alliance

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

PQA, Inc.

Description

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.

#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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Process

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Process

Data Source

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data

No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Health Plan

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Health Plan

Setting

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Outpatient Services

#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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.

#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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

Use the steps below to identify the numerator population:

Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days.

For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17.

Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The number of individuals from the denominator with:

- Two 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 two 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), do the following:

- Exclude any days' supply that occur after the end of the measurement year.
- 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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

The denominator includes individuals 18 years and older with two 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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement

year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period.

Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure.

Complete the steps below to determine the denominator population.

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice

• Cancer

• Sickle cell disease

Medication Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

#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 two 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 one-month gap in coverage (i.e., an individual whose coverage lapses for two 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, do the following,

- Exclude any days' supply that occur after the end of the measurement year.
- : 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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

#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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them:

•Hospice indicator from the enrollment database, if available (e.g. Medicare)

•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid)

Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.

•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.

•Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Exclude any individual in hospice during the measurement year, using the following to identify them:

- 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)

Exclude any individuals with cancer during the measurement year. Use the following 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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

No risk adjustment or risk stratification

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

No risk adjustment or risk stratification

Stratification

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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 ffederal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

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

#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 plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

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

Type Score

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Rate/proportion better quality = lower score

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

Rate/proportion better quality = lower score

Algorithm

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

A. Target population (denominator):

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice: Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using:

  - Hospice indicator from the enrollment database, if available (e.g. Medicare); or
  - One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid)

• Cancer: Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using:

o One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.

o Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

• Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.

B. Numerator Population:

Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods.

Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days).

For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17.

NOTE:

- The prescription can be for the same or different opioids.
- If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.
- If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.
- If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day.

Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator.

C. Measure Rate:

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

- Note: 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.

#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 one-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Step 3: Of those identified in step 2, identify individuals with two 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, do the following:

- Exclude any days' supply that occur after the end of the measurement year.
- 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: Use the following to identify individuals with cancer or in hospice during the measurement year.

:

- 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)

Use the following 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 two 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), do the following:

- Exclude any days' supply that occur after the end of the measurement year.
- 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 LIS and non-LIS populations separately.

Submission items

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).

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 (#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).

Comparison of NQF #3558 and NQF # 3541

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

Steward

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Pharmacy Quality Alliance

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

Pharmacy Quality Alliance

Description

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The percentage of individuals 18 years of age and older with one or more initial opioid prescriptions for greater than seven cumulative days' supply.

#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.

Type

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Process

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

Process

Data Source

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Claims, Enrollment Data Administrative claims: prescription claims, medical claims, Prescription Drug Hierarchical Condition Categories (RxHCCs); Enrollment data

No data collection instrument provided Attachment PQA_IOP_Value_Sets-637124369595574869.xlsx

#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

Level

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Health Plan

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

Health Plan

Setting

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Outpatient Services

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

Outpatient Services

Numerator Statement

#3558: Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

The opioid initiation period is defined as the date of service of the initial opioid prescription plus two days, i.e., the three-day time period when the numerator is assessed.

#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.

Numerator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The number of individuals from the denominator with greater than seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.

Use the steps below to identify the numerator population:

Step 1: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods, defined as the date of service of the initial opioid prescription plus two days.

For example, if the date of service for an initial opioid prescription is March 15, identify all opioid prescription claims from March 15 through March 17.

Step 2: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last dayyear.

Step 3: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year.

#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."

Denominator Statement

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals 18 years of age or older with one or more prescription claims for an opioid and a negative medication history for any opioid medication during the 90-day lookback period.

#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.

Denominator Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

The denominator includes individuals aged 18 years or older as of the first day of the measurement year with at least one prescription claim for an opioid medication during the measurement year with continuous enrollment during the measurement year and 90 days prior to the index prescription start date (IPSD) and a negative medication history for any opioid medication during the 90-day lookback period.

Individuals in hospice at any time during the measurement year or 90 days prior to the first day of the measurement year, and those with a cancer or sickle cell disease diagnosis during the measurement year or 90 days prior to the first day of the measurement year, are excluded from the measure.

Complete the steps below to determine the denominator population.

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (Medication Table OPIOIDS) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids (Medication Table OPIOIDS). For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3-July 31. Repeat for the September 15 and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: Exclude individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

• Hospice

• Cancer

• Sickle cell disease

Medication Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

#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 must fit the following qualifications:

1) 18 years of age and older as of the first day of the measurement year.

2) Cntinuously 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

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Individuals with cancer, sickle cell disease, or in hospice at any point during the measurement year or the 90 days prior to the first day of the measurement year are excluded from the denominator.

#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.

Exclusion Details

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Exclude any individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year, using the following to identify them:

•Hospice indicator from the enrollment database, if available (e.g. Medicare)

•One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. Commercial, Medicaid)

Exclude any individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year.

•One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.

•Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).

Exclude any individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

#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.”

Risk Adjustment

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

Stratification

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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 federal government to the drug plan for Medicare beneficiaries who need extra help with their prescription drug costs due to limited income and resources. Medicare beneficiaries apply for the LIS with the Social Security Administration or their state Medicaid agency.

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

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

Not applicable.

Type Score

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

Rate/proportion better quality = lower score

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

Rate/proportion better quality = lower score

Algorithm

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

A. Target population (denominator):

Step 1: Identify individuals 18 years or older as of the first day of the measurement year.

Step 2: Identify individuals with one or more prescription claims for an opioid (see Medication Table OPIOIDS, below) during the measurement year.

Step 3: Identify individuals continuously enrolled during the measurement year and the 90 days prior to the IPSD.

Step 4: Identify unique individuals with a negative medication history for any opioid medication during the 90-day lookback period.

For example, an individual has opioid prescription claims on August 1, September 15, and December 20. For each of these dates of service, use the lookback period of 90 days to determine if the individual had no prescription claims for opioids. For example, for August 1, determine whether the individual had no prescription claims for opioids from May 3 - July 31. Repeat for the September 15, and December 20 opioid prescription claims.

NOTE:

• The prescription can be for the same or different opioids.

• If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescription claim with the longest days' supply.

• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims regardless of overlapping days' supply.

• Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Step 5: (Exclusions) Identify individuals with any of the following during the measurement year or the 90 days prior to the first day of the measurement year:

- Individuals in hospice during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals in hospice using:
    - Hospice indicator from the enrollment database, if available (e.g. Medicare); or
    - One or more claims with place of service code 34 during the measurement year or 90 days prior to the first day of the measurement year, if hospice indicator is not available (e.g. commercial, Medicaid)

- Identify individuals with cancer during the measurement year or 90 days prior to the first day of the measurement year. Identify individuals with cancer using:
    - One or more claims with cancer in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, Cancer tab.
    - Pharmacy hierarchical condition category (RxHCC) 15, 16, 17, 18, 19 from the Medicare Part D risk adjustment model for payment year 2017 or 2018, if ICD codes are not available (available from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html).
- Identify individuals having one or more claims with sickle cell disease (SCD) in the primary diagnosis or any other diagnosis fields during the measurement year or 90 days prior to the first day of the measurement year. See PQA ICD Code Value Sets, SickleCellDisease tab.

Table OPIOIDS: Opioids

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

(Note: Includes combination products. Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products, as buprenorphine, as a partial opioid agonist, is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids.)

Step 6: Subtract the individuals identified in Step 5 (exclusions) from the population identified through Steps 1-4. The remaining individuals represent the denominator.

B. Numerator Population:

Step 7: For each individual in the denominator population, identify all initial opioid prescriptions and corresponding opioid initiation periods.

Step 8: For each individual, starting with each initial opioid prescription, sum the days' supply of all opioid prescriptions within each opioid initiation period (i.e., the initial opioid prescription + two days).

For example, if the date of service for an initial opioid prescription is March 15, identify any opioid prescription claims from March 15 through March 17.

NOTE:

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

- If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day .

Step 9: Count the unique individuals with greater than seven cumulative days' supply for all opioid prescription claims during any opioid initiation period in the measurement year. This is the numerator.

C. Measure Rate:

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

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

#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.

Submission items

#3558 Initial Opioid Prescribing for Long Duration (IOP-LD)

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

#3389 Concurrent Use of Opioids and Benzodiazepines (COB)

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Most of the PQA opioid measures (#2940, #2950, #2951, and #3389) use the same target population (denominator), and each have different areas of focus (numerator) related to opioid prescribing. The PQA AMO measure (NQF #3541, recommended for endorsement by the Behavioral Health and Substance Use Standing Committee and awaiting CSAC approval) shares a related denominator, but includes only individuals on long-term opioid therapy and has a different area of focus related to drug testing. 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 IOP-LD measure.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (i.e., those that address both the same measure focus and the same target population).

#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.

Appendix F: Pre-Evaluation Comments

Comments received as of June 5, 2020.

Topic	Commenter	Comment
3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	The American Medical Association (AMA)	The American Medical Association (AMA) strongly opposes the endorsement of NQF #3558: Initial Opioid Prescribing for Long Duration (IOP-LD) as we believe that the measure is not aligned with the evidence as specified and there are significant unintended negative consequences that could be experienced with the use of this measure. The AMA believes that all care provided to patients must be individualized and quality measurement should not focus on preventing and/or reducing opioid use. Rather measurement should address the larger clinical issue—how well patients' pain is controlled, whether functional improvement goals are met, and what therapies are being used to manage pain while also lowering the risk of addiction and developing an opioid use disorder (OUD). The ongoing singular focus on the dose and duration of opioid prescriptions disregards the important steps that the administration has taken to address the national epidemic of opioid-related overdose deaths, which the AMA strongly supports. The final report of the Department of Health and Human Services (HHS) Interagency Pain Management Best Practices Task Force, for example, made a compelling case for the need to focus on patients experiencing pain as individuals and to develop treatment plans that meet their individual needs and not employ one-size-fits-all approaches that assume prescriptions of long duration are indications of overuse (HHS, 2019). Likewise, a Centers for Disease Control and Prevention (CDC) publication in the New England Journal of Medicine (Dowell, 2019) expressed concern that its opioid prescribing guidelines have been misapplied and wrongly used to discontinue or reduce prescriptions for patients with pain with some actions likely to result in patient harm. The CDC stated that its guideline should not be used to create hard and fast policy; yet, it is the primary evidence provided to support this measure for accountability uses. Specifically, the AMA does not believe that the evidence cited in support of the measure is sufficient since the CDC guidelines used the arbitrary seven-day threshold as a voluntary recommendation rather than a hard threshold. As the AMA warned in 2016, the CDC voluntary recommendation was taken beyond its context and used by

Topic	Commenter	Comment
		state legislatures, pharmacy chains, pharmacy benefit managers, and health plans as authoritative to impose a hard, seven-day cap on opioid analgesic prescriptions and now we see it being used to hold a health plan accountable. Sole reliance on one guideline where the authors have explicitly voiced concerns with the inappropriate application of the recommendations should be avoided and we believe that the evidence subcriterion has not been met. The AMA is further concerned that the measure uses a 90-day lookback period to define individuals who are "opioid naïve." The CDC guideline does not define this population and the multiple studies cited throughout the measure submission form use varying timeframes (e.g., 60 days, 12 months). As a result, we believe that the use of a 90-day lookback period could drive inappropriate treatment decisions and the lack of an agreed upon definition for "opioid naïve" should prohibit this committee from determining that the measure as specified is evidence-based. The AMA also believes that the numerator will incorrectly include those individuals who receive methadone for OUD treatment. Currently, the measure specifications consider methadone to be one of the opioid medications that should be included but because it does not exclude those patients with a diagnosis of OUD, anyone who receives one or more prescriptions for methadone for greater than seven days will be considered to meet the numerator. We believe that the measure must address this error since it will lead to misrepresentations of performance and could lead to inappropriate treatment decisions in an effort to improve performance scores. Lastly, the AMA is concerned with the usability of the measure and believes that there is significant potential for unintended negative consequences. While this measure is currently focused on health plan performance, there is great risk that it will lead to denials of medication in all instances even when an opioid is appropriately prescribed. Given these significant concerns, the AMA does not support this measure and urges the Standing Committee not to recommend its endorsement. References:

Topic	Commenter	Comment
		Dowell D, Haegerich T, Chou R. No shortcuts to safer opioid prescribing. N Engl J Med. 2019;380:2285–7. https://doi.org/10.1056/NEJMp1904190. U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices InterAgency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html.
3558: Initial Opioid Prescribing for Long Duration (IOP-LD)	The Federation of American Hospitals (FAH)	The Federation of American Hospitals (FAH) appreciates the opportunity to comment on this measure prior to the Standing Committee's evaluation. The FAH recognizes the need to address inappropriate opioid use given the ongoing concerns around this important public health issue, but we believe that measure must be aligned with evidence, provide useful information to accurately represent performance, and allow patients to make informed decisions. The FAH requests that the committee consider whether the definition of "opioid naïve" used in this measure is aligned with current evidence and would not lead to inappropriate treatment decisions in an effort to improve performance scores. Specifically, the Centers for Disease Control and Prevention (CDC) guideline on which this measure is based does not explicitly define "opioid naïve" and the timeframes used in the other studies cited in the evidence form and throughout the submission vary from six months up to 12 months. As a result, it is not clear how the measure developers determined that a 90-day lookback period was the correct definition for "opioid naïve". The FAH does not believe that measures used for accountability purposes should include specifications on which timeframes are selected in the absence of any consistent evidence and the resulting potential unintended negative consequences must be considered. The FAH requests that the committee discuss the lack of any evidence to support this lookback period and determine whether the measure as specified meets the NQF measure evaluation criteria.

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