

Understanding the CMS measure Concurrent Use of Opioids and Benzodiazepines (COB): a guide for providers

Concurrent Use of Opioids and Benzodiazepines (COB) is a new Centers for Medicare & Medicaid Services (CMS) star measure starting in measurement year (MY) 2025. As health care providers, staying informed about CMS measures is crucial for maintaining high-quality care and ensuring compliance with regulatory standards.

What is the COB measure?

The COB measure evaluates the percentage of Medicare Part D patients with concurrent use of prescription opioids and benzodiazepines. The measure looks for patients age 18 or older who receive two or more opioid prescriptions, filled on different days, totaling at least 15 days during the measurement year, and identifies if they are concurrently prescribed and filling benzodiazepines for 30 or more total days.

Why is the COB measure important?

The concurrent use of benzodiazepines with other central nervous system (CNS) depressants, such as opioids, can increase risk of respiratory depression, which can lead to death.

- A study published in JAMA Psychiatry found that combined use accounts for a significant portion of prescription drug-related deaths.¹
- Avoiding unnecessary concurrent use can reduce adverse events, enhance quality of life and improve overall patient safety.
- CMS aims to reduce avoidable hospitalizations and improve patient safety by targeting inappropriate polypharmacy practices.²
- Misuse of these medications contributes to the opioid epidemic, making this a critical area for quality improvement.

Patients excluded from COB measure

- Patients with a cancer diagnosis coded during the measurement year
- Patients with sickle cell disease coded during the measurement year
- Patients enrolled in hospice or palliative care

Best practices and tips for success

- Medication review and risk assessment
 - Regularly review patient medication lists and consult Prescription Drug Monitoring Programs (PDMPs) to prevent duplicate or unsafe prescriptions.
- Consider non-benzodiazepine alternatives.

- For anxiety, consider SSRIs (e.g., sertraline) or SNRIs (e.g., duloxetine) as first-line options.
- For insomnia, recommend cognitive behavioral therapy for insomnia (CBT-I) or non-benzodiazepine options (e.g., zolpidem).
- Tapering and discontinuation strategies
 - Gradually reduce benzodiazepine or opioid use to minimize withdrawal risks, following CDC guidelines.³
- Patient education
 - Inform patients of the risks associated with combined opioid and benzodiazepine use and the importance of adhering to prescribed therapies.
- Collaborative care
 - Engage behavioral health specialists and pain management professionals to provide holistic care for underlying conditions.

Please visit the CMS website or contact our quality improvement team for further information and resources on the COB measure.

Measure medications:

Opioid medications		
benzhydrocodone	hydrocodone	oxycodone
buprenorphine	hydromorphone	oxymorphone
butorphanol	levorphanol	pentazocine
codeine	meperidine	methadone
dihydrocodeine	morphine	tapentadol
fentanyl	opium	tramadol
Benzodiazepine medications		
alprazolam	diazepam	oxazepam
chlordiazepoxide	estazolam	quazepam
clobazam	flurazepam	temazepam
clonazepam	lorazepam	triazolam
clorazepam	midazolam	

References:

1. Ray, W. A., Chung, C. P., Murray, K. T., Cooper, W. O., & Hall, K. (2017). Prescription of Long-Acting Opioids and Mortality in Patients with Chronic Noncancer Pain. *JAMA Psychiatry*, 74(11), 1044–1051.
2. Centers for Disease Control and Prevention (CDC). (2016). Guideline for Prescribing Opioids for Chronic Pain. Available at: CDC Website.

3. Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. *MMWR Recommendations and Reports*, 65(1), 1-49.