Proposed Cross-Cutting Exclusion for HEDIS®[1] MY 2020
Palliative Care

NCQA seeks comments on implementing a cross-cutting exclusion for members receiving palliative care in the following 13 HEDIS Health Plan measures:

- *Risk of Continued Opioid Use.*
- *Use of Opioids at High Dosage.*
- *Potentially Harmful Drug Interactions in Older Adults.*
- *Use of High-Risk Medications in Older Adults.*
- *Breast Cancer Screening.*
- *Cervical Cancer Screening.*
- *Colorectal Cancer Screening.*
- *Osteoporosis Screening in Older Women.*[2]
- *Comprehensive Diabetes Care.*
- *Controlling High Blood Pressure.*
- *Osteoporosis Management in Women Who Had a Fracture.*
- *Statin Therapy for Patients With Cardiovascular Disease.*
- *Statin Therapy for Patients With Diabetes.*

With the recent addition of opioid measures to HEDIS, stakeholders identified individuals receiving palliative care as a population that should be considered for removal from these measures. Therefore, NCQA is assessing the clinical appropriateness and feasibility of excluding individuals receiving palliative care from a group of selected HEDIS measures, because quality measures designed for a general population may not be clinically appropriate or a priority for these individuals.

Palliative care is an approach focused on pain and other symptom relief for individuals with serious illnesses. The focus on comfort in palliative care may warrant the use of certain medications (e.g., opioids for pain management) that are likely inappropriate for use in the general population. NCQA is considering applying a palliative care exclusion to selected prevention/screening and condition/disease specific management measures, in addition to the inappropriate medication use measures. *Opioids from Multiple Providers* (UOP) was not selected for inclusion, because individuals receiving palliative care are at increased risk for opioid use disorder and other medication errors if they receive prescriptions from multiple providers, and should be provided appropriate care coordination to reduce this risk.

Our expert panels supported implementing an exclusion for members with palliative care for the measures listed above. Based on expert panel feedback, the exclusion is defined using the codes in the Palliative Care value set and has been made more specific by 1.) using codes that indicate receipt of palliative care, not referral for palliative care; 2.) identifying recent receipt of palliative care; and 3.) requiring at least two occurrences of a palliative care code on different dates of service.

Supporting documents include an example specification with the proposed exclusion incorporated and evidence workup.

NCQA acknowledges the contributions of the Geriatric Measurement Advisory Panel, the Technical Measurement Advisory Panel, and the Exclusions Expert Work Group.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] *Osteoporosis Screening in Older Women (OSW)* is a new measure being recommended during the Public Comment period for implementation in the HEDIS Measurement Year 2020.

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*Risk of Continued Opioid Use (COU)**

***Adapted with financial support from CMS from a measure developed by the Minnesota Department of Human Services.**

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Added a palliative care exclusion to the event/diagnosis criteria.

Measure Description

The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members with at least 15 days of prescription opioids in a 30-day period.
2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.

Note: *A lower rate indicates better performance.*

Measure Definitions

Intake Period

A 12-month window starting on November 1 of the year prior to the measurement year and ending on October 31 of the measurement year.

IPSD

Index Prescription Start Date. The earliest prescription dispensing date for an opioid medication during the Intake Period.

Negative Medication History

A period of 180 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an opioid medication.

Calculating number of days covered for the numerator

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

For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the measurement year only once toward the numerator.

If multiple prescriptions for the same medication are dispensed on the same day or different days with overlapping days supply, sum the days supply and use the total to calculate the number of days covered by an opioid medication. For example, two prescriptions for the same medication are dispensed on the same day, each with a 30-day supply. Sum the days supply for a total of 60 days covered by an opioid medication.

Subtract any days supply that extends beyond the end of the 30-day period (Rate 1) or 62-day period (Rate 2).

To identify same or different drugs, use the medication lists specified for the measure in the Opioid Medications table below. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Acetaminophen Codeine Medications List is considered a different drug than a dispensing event from the Codeine Sulfate Medications List.

Eligible Population

***Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Age 18 years and older as of November 1 of the year prior to the measurement year.

Report two age stratifications and a total rate.

- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment 180 days prior to the IPSD through 61 days after the IPSD.

Allowable gap No gaps in enrollment.

Anchor date None.

Benefit Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population, which is used for both rates.

Step 1 Determine the IPSD. Identify the date of the earliest dispensing event for an opioid medication during the Intake Period. Use all the medications lists in the Opioid Medications table below to identify opioid medication dispensing events.

Step 2: Required exclusions Exclude members who met at least one of the following at any time during the 12 months (1 year) prior to the IPSD through 61 days after the IPSD:

- Cancer (Malignant Neoplasms Value Set).
- Sickle cell disease (Sickle Cell Anemia and HB S Disease Value Set).
- Palliative care (Palliative Care Value Set) on at least two different dates of service.

Step 3 Test for Negative Medication History. Exclude members who filled a prescription for an opioid medication within 180 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 180 days prior to the IPSD through 61 days after the IPSD.

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Administrative Specification

Denominator The eligible population.

Numerator Use all the medication lists below to identify opioid medication dispensing events for the numerator. Calculate covered days using the instructions in the measure definition.

≥15 Days Covered Members who had 15 or more calendar days covered by an opioid medication during the 30-day period beginning on the IPSD through 29 days after the IPSD.

≥31 Days Covered Members who had 31 or more calendar days covered by an opioid medication during the 62-day period beginning on the IPSD through 61 days after the IPSD.

Opioid Medications

Prescription	Medication Lists
Buprenorphine (transdermal patch and buccal film)	• Buprenorphine Medications List
Butorphanol	• Butorphanol Medications List
Codeine	• Acetaminophen Butalbital Caffeine Codeine Medications List • Acetaminophen Codeine Medications List • Aspirin Butalbital Caffeine Codeine Medications List • Aspirin Carisoprodol Codeine Medications List • Codeine Sulfate Medications List
Dihydrocodeine	• Acetaminophen Caffeine Dihydrocodeine Medications List • Aspirin Caffeine Dihydrocodeine Medications List
Fentanyl	• Fentanyl Medications List
Hydrocodone	• Acetaminophen Hydrocodone Medications List • Hydrocodone Medications List • Hydrocodone Ibuprofen Medications List
Hydromorphone	• Hydromorphone Medications List
Levorphanol	• Levorphanol Medications List
Meperidine	• Meperidine Medications List • Meperidine Promethazine Medications List
Methadone	• Methadone Medications List
Morphine	• Morphine Medications List • Morphine Naltrexone Medications List
Opium	• Belladonna Opium Medications List • Opium Medications List
Oxycodone	• Acetaminophen Oxycodone Medications List • Aspirin Oxycodone Medications List • Ibuprofen Oxycodone Medications List • Oxycodone Medications List
Oxymorphone	• Oxymorphone Medications List
Pentazocine	• Naloxone Pentazocine Medications List

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Prescription	Medication Lists
Tapentadol	• Tapentadol Medications List
Tramadol	• Acetaminophen Tramadol Medications List • Tramadol Medications List

Note

- *Do not include denied claims when identifying the eligible population (except for required exclusions) or assessing the numerator for this measure.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*
- *The following opioid medications are excluded from this measure:*
  - *Injectables.*
  - *Opioid-containing cough and cold products.*
  - *Single-agent and combination buprenorphine products used as part of medication-assisted treatment of opioid use disorder (buprenorphine sublingual tablets, buprenorphine subcutaneous implant and all buprenorphine/naloxone combination products).*
  - *Ionsys® (fentanyl transdermal patch).*
    - *This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).*
  - *Methadone for* the *treatment of opioid use disorder.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COU-1/2/3: Data Elements for Risk of Continued Opioid Use

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total*
Number of required exclusions	*For each age stratification and total*
Numerator events by administrative data	*Each rate, for each age stratification and total*
Reported rate	*Each rate, for each age stratification and total*

Cross-Cutting Palliative Care Exclusions for HEDIS Measures

Topic Workup

Background on Cross Cutting Exclusions

NCQA seeks to refine and increase the validity of selected HEDIS measures by excluding individuals for whom the measures are not clinically appropriate or relevant. HEDIS quality measures are designed to be scientifically valid, reliable and feasible for comparing the quality of care provided to general populations, such as healthy older adults or those with a single chronic condition. Over time, HEDIS measures have been increasingly used in national reporting programs, placing strong incentives (including financial) on measure performance.

NCQA has applied cross-cutting exclusions to HEDIS measures: Individuals receiving hospice care are excluded from all HEDIS measures; older adults in Medicare living long-term in nursing home settings are excluded from selected measures; and older adults (across all product lines) with advanced illnesses and/or frailty are excluded from selected measures.[1] For those with limited life expectancy or advanced illness, the care to be provided in some measures may not be relevant or in line with their goals of care. For example, prevention and screening measures developed for a general population may not be clinically appropriate for those at end of life or with advanced illness, because the benefit of screening is not likely to be realized in the individual's lifetime. Likewise, a disease-specific management service, such as medication therapy, may be contraindicated, complicate care or not take precedence, given a patient's serious condition. By excluding these populations, providers and members are encouraged to utilize shared decision making to ensure delivery of patient-centered care.

As with individuals in hospice care, those receiving palliative care are receiving comfort care for the symptoms of serious illness (National Institute on Aging [NIA], 2017). The focus on comfort in palliative care may warrant the use of certain medications (e.g., opioids for pain management) that are likely inappropriate for use in the general population. Quality measures designed and intended for a general population may not be clinically appropriate or a priority for individuals receiving palliative care. NCQA therefore proposes a cross-cutting exclusion to account for these individuals. This workup gives an overview of the population being considered for exclusion from selected quality measures.

Individuals Receiving Palliative Care

Palliative care is an approach meant to improve quality of life for patients and their families who are facing the problems associated with life-threatening or serious illness. This type of care focuses on prevention and relief of suffering through early identification, assessment and treatment of pain and other problems, including physical, psychosocial and spiritual (WHO, 2017). Palliative care is a resource for anyone living with a serious illness and can be helpful at any stage of an illness (Center to Advance Palliative Care, 2019; NIA, 2017). It differs from hospice, where the focus is on terminal illness and providing comfort during the last six months of a patient's life (CMS, 2015). Curative treatments are not pursued in hospice care; a patient receiving palliative care can receive treatments to cure their illness (NIA, 2017).

Palliative care should involve a multidisciplinary team of providers, social workers, nutritionists, chaplains and other specialists (National Hospice and Palliative Care Organization (NHPCO), 2019; NIA, 2017). Services include pain and symptom management, care coordination with current physicians, patient/family counseling, caregiver support and advanced care planning (CAPC, 2019; NHPCO, 2019). Services can be offered in hospitals, nursing homes, outpatient palliative care clinics and other specialized clinics, or at home (NIA, 2017).

Receiving palliative care often indicates a patient has been diagnosed with one or more of these conditions: cardiovascular disease, cancer, chronic respiratory disease, AIDS, diabetes, kidney failure, chronic liver

[1] https://blog.ncqa.org/improving-care-advanced-illness-frailty/

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disease, Parkinson's disease, rheumatoid arthritis, neurological disease or dementia (WHO, 2017; NIA, 2017). According to the World Health Organization, of the 40 million people who need palliative care each year, approximately 39% have cardiovascular diseases, 34% have cancer and 10% have chronic lung disease. However, it is estimated that only 14% of those who need palliative care receive it (WHO, 2017). Limited number of specialists in palliative care, limited health insurance coverage for services and misconceptions about this care may prevent individuals from receiving palliative care (Ollove, 2017; Meier, 2011; Lupu, 2010). Although many insurance plans may cover hospice services, few cover palliative care specifically. Palliative care services covered by insurance plans, including Medicare and Medicaid, are often limited to those provided by or overseen by physicians, due to billing requirements determined by the plan, and may require copayment (National Association for Home Care & Hospice, 2015).

One of the most frequent and serious symptoms people receiving palliative care experience is pain. About 80% of patients with AIDS or cancer and 67% of patients with cardiovascular disease or COPD will experience moderate-to-severe pain as their condition progresses (WHO, 2016). In its step-care approach, the WHO recommends first starting a patient with a nonsteroidal anti-inflammatory drug, such as ibuprofen, switching to an opioid medication if pain continues or worsens. The WHO includes opioid analgesics codeine and morphine in its list of essential medicines for palliative care; however, regulatory or legislative restrictions on opioid medications can limit access for those in palliative care. Relief of emotional, psychosocial and spiritual pain is also highly emphasized in palliative care (WHO, 2016).

Palliative care can improve quality of life and lower symptom burden (Cunningham et al., 2017; Kavalieratos, et al., 2016). Metastatic lung cancer patients who received palliative care at the time of diagnosis suffered less depression, were less likely to receive aggressive end-of-life care and actually lived longer (11.6 months) than patients who received standard cancer care (8.9 months) (Temel, et al., 2010). Cancer patients are also more likely to complete their course of treatment and experience better quality of life when receiving palliative care (Cheville et al., 2015). Studies suggest that palliative care for patients with heart failure diagnosis can lead to improved quality of life and satisfaction, in addition to lowered risk of rehospitalization and psychological symptoms (Diop et al., 2017; Enguidanos and Portanova, 2012). Professional organizations, such as the American Society of Clinical Oncology, American Heart Association and American Stroke Association, recommend the use and integration of palliative care in the care of individuals with serious illnesses (Braun et al., 2016; Ferrell et al., 2017).

Palliative care has been shown to reduce avoidable health care spending and utilization. According to the Center to Advance Palliative Care, palliative care decreases inpatient readmissions by 48% and outpatient visits by 50% (2019). Research has found that having a palliative consultation early (within 3 days of hospitalization) is associated with reduced direct costs for hospitalized adults, as well as earlier referrals to appropriate care (Fitzpatrick et al., 2018; May et al., 2018). When offered in skilled nursing facilities or home-based settings, palliative care reduces hospital and ED admissions, hospital readmission and hospital length of stay (CAPC, 2019; Cassel et al., 2016; Scibetta et al., 2016). Home-based programs reduce 36% of total costs, saving as much as $12,000 per person receiving palliative care, compared to those in usual care (CAPC, 2019; Lustbader et al., 2016; Morrison et al., 2011).

Currently in the United States, there are over 1,800 hospitals with a palliative care program (CAPC, 2019); however, access remains a challenge for many patients. State initiatives and strategies to advance palliative care play a large role in addressing access issues. In 2018, a National Academy for State Health Policy (NASHP) review found that states have regulations and reimbursement strategies that promote palliative care. These include requiring hospitals and other facilities to provide information to patients on palliative care; requiring continuing medical education for physicians in end-of-life care, palliative care and/or pain management; and integrating palliative care benefits into Medicaid programs (NASHP, 2018). Unfortunately, over half of states have not begun to use state policies to strengthen palliative care programs (NASHP, 2018). To further this work, NASHP recommends other strategies, such as regulating health insurance coverage, using state policies to define palliative care services and reimbursement and implementing palliative care standards/quality metrics.

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