

Proposed New Measure for HEDIS^{®1} MY 2022: Advance Care Planning (ACP)

NCQA seeks comments on a proposed new measure for potential inclusion in the HEDIS measure set for Measurement Year 2022:

- *Advance Care Planning*: The percentage of adults who had advance care planning during the measurement year:
 - Adults 65–80 years of age with advanced illness, frailty or palliative care *and*
 - Adults 81 years of age and older.

Advance care planning is a continuous process of conversation and documentation to align a patient's care and interventions with their beliefs, values and preferences if they become unable to make care decisions. The Centers for Medicare & Medicaid Services began reimbursing for this service in 2016. Providers may bill for advance care planning without limitation of diagnosis, frequency or place of service. Advance care planning is associated with positive outcomes including improved quality of life, decreased hospitalization and increased provider trust,^{2,3} but its benefits are not fully realized by members due to underutilization and lack of documentation.

Advance care planning is currently captured as one of four indicators in the HEDIS *Care for Older Adults (COA)* measure, which assesses for evidence of advance care planning among members 65 and older. It is limited to Special Needs Plans and Medicare-Medicaid Plans and uses the Administrative and Hybrid reporting methodologies. This new administrative-only measure expands advance care planning to all Medicare Advantage plans and transitions away from the more resource-intensive Hybrid reporting methodology.

Focusing the measure on members 65–80 with advanced illness, frailty or palliative care and on all members 81+ emphasizes advance care planning use for people who benefit most: those likely to have more complex health status. The measure also addresses feasibility and concerns about the potential for conducting advance care planning discussions too frequently with members whose health status may not have changed significantly.

Testing revealed that identifying individuals who have engaged in advance care planning can be feasibly reported at the plan level. Testing showed wide variation in performance across plans, signaling a gap in quality care and an opportunity for improvement in conducting advance care planning. Average plan-level performance for members 65–80 with advanced illness, frailty or palliative care and members 81+ was 16.7%; performance ranged from a rate of 4.5% at the 10th percentile of distribution to 73.2% at the 90th percentile.

NCQA seeks general feedback on the measure and specific feedback on the following question:

1. The proposed new measure requires advance care planning at least once every year. During development, advisory panels gave mixed feedback on this requirement. With no current clinical guidance on periodicity *between* years, NCQA seeks feedback on how frequently advance care should happen between years for this population.

Supporting documents for this measure include the draft measure specifications and evidence workup.

NCQA acknowledges the contributions of the Geriatric Measurement Advisory Panel and the Care Coordination Work Group.

¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

² Martin, R.S., B. Hayes, K. Gregorevic, & W.K. Lim. 2016. "The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review." *Journal of the American Medical Directors Association* 17(4), 284–93. <https://doi.org/10.1016/j.jamda.2015.12.017>

³ Rosenberg, A.R., B. Popp, D.S. Dizon, A. El-Jawahri, & R. Spence. 2020. "Now, More Than Ever, Is the Time for Early and Frequent Advance Care Planning." *Journal of Clinical Oncology*, JCO.20.01080. <https://doi.org/10.1200/JCO.20.01080>

Advance Care Planning (ACP)

SUMMARY OF CHANGES TO HEDIS MY 2022

- First-year measure.

Description

The percentage of adults 66–80 years old with advanced illness, frailty or palliative care, and adults 81 years of age and older, who had advance care planning during the measurement year.

Definitions

| | |
|------------------------------|--|
| Advance care planning | A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end-of-life care. |
|------------------------------|--|

Eligible Population

| | |
|------------------------------|--|
| Product line | Medicare. |
| Ages | Members 66 and older as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in continuous enrollment of up to 45 days. |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/diagnosis | <p>Follow the steps below to identify the eligible population.</p> <p>Step 1 Include all members 81 years of age and older as of December 31 of the measurement year.</p> <p>Step 2 Include members 66–80 years of age as of December 31 of the measurement year who meet any of the following criteria.</p> <ul style="list-style-type: none"> • Advanced Illness: Members who meet any of the following during the measurement year: <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>), telephone visits (<u>Telephone Visits Value Set</u>), e-visits or virtual check-ins (<u>Online Assessments Value Set</u>), nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim. 3. Identify the discharge date for the stay. |

- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
- At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
- A dispensed dementia medication (Dementia Medications List).

Dementia Medications

| Description | Prescription | | |
|---|-----------------------|---------------|----------------|
| Cholinesterase inhibitors | • Donepezil | • Galantamine | • Rivastigmine |
| Miscellaneous central nervous system agents | • Memantine | | |
| Dementia combinations | • Donepezil-memantine | | |

- *Frailty*: Members who had a claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
- *Palliative Care*: Members who had a claim/encounter for palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

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

Administrative Specification

Denominator The eligible population.

Numerators Evidence of advance care planning during the measurement year (Advance Care Planning Value Set).

Data Elements for Reporting

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

Table ACP-3: Data Elements for Advance Care Planning

| Data Elements | Administrative |
|---|----------------|
| Measurement year | ✓ |
| Eligible population | ✓ |
| Numerator events by administrative data | ✓ |
| Numerator events by supplemental data | ✓ |
| Reported rate | ✓ |

Advance Care Planning (ACP) Measure Workup

Topic Overview

Advance care planning is a continuous process of conversation and documentation to align a patient's care and interventions with their beliefs, values and preferences, in the event they become unable to make those decisions. The Centers for Medicare & Medicaid Services (CMS) describes advance care planning as a face-to-face service to discuss a patient's health wishes that may or may not include completing relevant documentation (CMS, 2019). Prior to the COVID-19 pandemic, advance care planning conversations could take place virtually if they included both audio and video and occurred in select locations (originating site) (CMS, 2020; Rosenthal & Nintean, 2020). These barriers have been removed during the pandemic, increasing access to advance care planning.

A number of documents may be completed as a result of the advance care planning conversation in order to capture a patient's wishes and goals for care. These documents are generally referred to as "advance directives" and can include:

- **Durable Power of Attorney for Health Care (DPAHC):** Also referred to as a "health care proxy" or "health care power of attorney," a signed legal document that authorizes another person to make medical decision on a patient's behalf if they lose capacity (Silveria, Arnold & Givens, 2020).
- **Living Will:** A document summarizing an individual's preferences for future medical care. A living will typically addresses resuscitation and life support, but may also cover other preferences, including pain control or hospitalization (Silveria, Arnold & Givens, 2020).
- **Combined Directives:** Include components of a living will, the values history (i.e., evaluation of the patient's values and advance directives) and the instructional directive and designate a surrogate decision maker (Silveria, Arnold & Givens, 2020).
- **Physician Orders for Life-Sustaining Treatment (POLST):** Also referred to as "Medical Orders for Scope of Treatment" (MOLST), dictate what care should be administered or withheld, as directed by a physician. Typically used for patients nearing the end of life or who are seriously ill (Silveria, Arnold & Givens, 2020).

In addition to these documents, a patient may identify a surrogate decision maker to serve as their representative and decision maker in the event they cannot make decisions for themselves. Surrogate decision makers make decisions for the patient in a given situation based on what they believe the patient would want (Silveria, Arnold & Givens, 2020).

Individuals at any stage of life and health status can benefit from advance care planning to guide their future care. For most, it results in the creation of an advance directive or naming a surrogate decision maker. Individuals who are seriously ill, such as those with advanced chronic conditions or limited life expectancies, also benefit from advance care planning. For these individuals, advance care planning guides their current care and may result in medical orders from a physician documenting their care preferences.

Importance and Prevalence

Although it is widely agreed that advance care planning is a critical part of patient care, evidence indicates that only between 35% and 38% of individuals have some form of an advance care plan (Yadav et al, 2017; Lendon et al., 2018). 70% of providers indicated that they only have advance care planning conversations with their patients experiencing advanced illness (Bires et al., 2017). The benefits of advance care planning may only be realized if the care team has access to and follows the patient's advance care plan. One study found that while 70% of patients were familiar with advance directives, only 35% had completed one.

Another study found that among participants in an employer health incentive program, 95% indicated they had someone they had someone who could make medical decisions for them if they were unable, but only 23% had documented that information—and only 11% had shared that information with their health care provider (Gonzales et al., 2018).

With the COVID-19 pandemic, the value and importance of advance care planning has increased. A study found that most older adults at risk for morbidity or mortality due to COVID-19 had not sufficiently planned before admission to an intensive care unit (Block, Smith & Sudore, 2020). However, New York State has seen an increase in completion of electronic medical orders for life sustaining treatment (eMOLST) and “renew and review” discussions with patients who to confirm or update their eMOLST forms due to health status, prognosis or changing goals during the pandemic (Bomba & Orem, 2020).

Supporting Evidence

Financial importance and cost-effectiveness

Advance care planning is associated with decreased use of costly, intensive and ineffective treatments at the end of life and increased use of palliative care practices linked to both improved patient and survivor well-being (Institute of Medicine, 2015). In a retrospective cohort study, seriously ill patients with billed advance care planning encounters were more likely than those without advance care planning encounters to receive hospice services and were less likely to receive life-sustaining therapies such as chemotherapy (Ashana, 2019).

Relationship to outcomes

It is widely agreed that advance care planning is a critical part of patient care, as it can lead to improved end-of-life care, increased trust in providers, decreased psychological distress and improved quality of life, and can facilitate hope (Rosenberg et al., 2020). Patients with advance care plans have been found to experience improved quality of care at the end of life (Bischoff et al., 2013). A systematic review found that among nursing home respondents, advance care planning can reduce hospitalizations between 9% and 26%, decrease costs and increase compliance with patients’ wishes (Martin et al., 2016).

Among patients with advanced cancer, those who completed a POLST were more likely to die out of the hospital or be admitted to hospice, compared to patients who only completed an advance directive, suggesting that POLST completion may contribute to higher rates of goal-concordant care (Pedraza et al., 2017). Furthermore, after implementing a quality improvement project to develop, implement and evaluate the usefulness of advance care planning, a study saw significant increases in advance care planning and POLST completion. Of about 54% of patients who completed a POLST and were admitted to the hospital, 94% of these patients’ documented wishes were honored (Cantillo et al., 2017).

An observational study in LaCrosse County, Wisconsin, found that a system for advanced care planning can be managed in a geographic region so that at the time of death, almost all adults have an advance care plan that is specific and available, and treatment is consistent with their plan. Data from this study suggest that quality efforts have improved the prevalence, clarity and specificity of advanced care plans (Hammes, 2010).

Health care disparities

In a study conducted by Kulkarni et al. (2011) among 369 multiethnic, multilingual participants, fewer than half (41%) reported discussing an advance care plan with their physician during a hospitalization. Advance care

planning rates are lower among the older Black and Latino populations than the White population (Carr, 2011). Estimates vary across samples, but most research studies found that when compared to their White counterparts, African Americans are less likely to participate in advance care planning and are more likely to informally discuss end-of-life care than formally document their wishes (Sanders et al, 2016). A study conducted by Harrison et al. (2016) found that 2012 Medicare beneficiaries who were Latino, African American, less educated or of lower income were less likely to have participated in advance care planning.

In a study of beliefs about advance care planning in cancer patients at an urban, multispecialty cancer center, researchers found differences among both providers and patients in terms of their knowledge, preferences and practices related to advance care planning. 100% of White patients and 45.5% of Black patients were familiar with advance directives, but only 55.6% of White patients and 18.2% of Black patients reporting having one (Bires et al, 2017).

Gaps in care

When patients and families do not engage in advance care planning, it can result in unwanted end-of-life care or care that does not align with the patient's values. In an Australian study, researchers found that older adults participate in advance care planning discussions (most often with members of their family) when they are given an opportunity to reflect on their values and goals, convey and document their treatment preferences and choose a health care agent. These discussions result in patients being almost three times as likely to have their end-of-life wishes both known and followed. Additionally, their family members endure significantly less stress, depression and anxiety after their loved one dies (Detering, 2010).

Advanced illness, frailty and palliative care

Among a national sample of Medicare Advantage beneficiaries with serious illness, those with a documented advance care planning encounter were more likely to be enrolled in hospice or die within six months of the encounter. Patients with a documented advance care planning encounter were also more likely to be hospitalized, including in the intensive care unit, but were less likely to receive intensive therapies (Ashana et al., 2019). A 2015 study found that patients with advanced cancer did not experience an increase in hopelessness or a decrease in hope after having an advance care planning encounter (Green et al., 2015); another study found that advance care planning can reduce decisional conflict for surrogate decision makers of critically ill patients (Charchiaro et al., 2015).

Among physicians, one study found that only 15% of cardiologists felt it was their responsibility to have an advance care planning conversation with their congestive heart failure patients, compared to 68% of primary care physicians who felt it was their responsibility. The same study found that 68% of oncologists felt it was their responsibility to have an advance care planning conversation with their patients diagnosed with terminal cancer, compared to 34% of primary care physicians (Chandar et al., 2017).

Older adults experiencing frailty may benefit from advance care planning conversations (Frechman et al., 2020). A 2013 systematic review found that the majority of frail older adults would welcome the chance to discuss their end-of-life care (Sharp et al, 2013). One study found that at the one-year follow up, 93% of older frail adults living in residential care homes who received facilitated conversations about advance care planning completed an

advance directive and 94% had identified a surrogate decision maker (Overbeek et al., 2018). When asked, most physicians felt it was their responsibility to initiate the discussion with older frail adult patients but felt restricted by time pressures and the lack of a precipitating event (Sharp et al., 2013).

Advance care planning is an important part of palliative care (Harrison, Denning, Sampson & Vries, 2019). Among adults with congenital heart disease, one study found that 69% of participants were willing to engage in an advance care planning conversation, 79% were willing to discuss goals and care preferences and 91% were willing to speak to a clinician who specializes in palliative care (Steiner et al., 2018). A 2018 systematic review found that including advance care planning as part of palliative care for patients with heart failure can reduce hospitalizations and support patients end-of-life preferences. Advance care planning was also found to increase referrals to and utilization of palliative care services in this population (Kernick et al., 2018).

Policy and Payment

CMS began paying for voluntary advance care planning services in 2016. There are no place-of-service limitations, diagnosis requirements or limitations on the number of times a beneficiary can receive advance care planning in a year. Providers may bill for an advance care planning conversation even if the patient does not wish to have the conversation or does not wish to complete forms at that time.

In response to COVID-19, CMS has significantly reduced restrictions on the use of telehealth. While advance care planning was previously allowed to take place virtually, there were a number of criteria for the encounter to be considered reimbursable, including that the visit took place in a specific location (originating site) and that the visit used both audio and video. Removing these requirements has increased access to advance care planning (CMS, 2020; Rosenthal & Ninteanu, 2020). Permitting audio-only visits aims to increase access for groups who have historically low rates of advance care planning, including those who are economically disadvantaged, residing in remote or underserved areas or lacking the device or internet connection necessary to sustain a video visit (Rosenthal & Ninteanu, 2020).

Barriers for completing or continuing the advance care planning conversation remain, especially during the COVID-19 pandemic. For example, a patient who has an advance care planning conversation with a specialist could incur a significant copay, depending on the specialist. Additionally, in an effort to save time, CMS issued a waiver allowing hospital staff to skip the *Patient Self Determination Act of 1990* requirement to inform a patient about the facility's policies for advance directives, which could lead to more challenging, less goal-concordant decision making after admission (Rosenthal & Ninteanu, 2020).

Care Coordination

Advance care planning is intended to engage patients in proactive conversations and documentation about their care preferences in the event they cannot independently express them. Successful advance care planning ensures that documentation is easily accessible as patients move through the care continuum, allowing more coordinated, goal-concordant care (Advance Care Plan Decisions, 2019).

Advance care planning can occur in a variety of settings (outpatient care, hospital, nursing facility, community and at home) and through the support of a variety of professionals (clinical, social, religious, legal), which can result in fragmented storage and information sharing that limits the benefit of advance care planning for patients, families and providers during a time of need. The importance of information exchange for advance care planning is recognized and there are efforts to encourage better coordination through electronic data sources.

Electronic medical records

A Massachusetts study completed in 2018 found that it was common for advance care plan documentation to be scanned into electronic medical records (EMR); however, these documents were either rarely or poorly digitized. Advance care planning documentation was likely to be stored in nonspecific media folders and very few systems had advance care planning modules built into their EMR. Modules that were specific to advance care planning were amenable to tracking details such as code status preference, specific notes and historic advance care planning documents (Kim, 2018).

State registries

The functionality of some state registries is narrow and only allows patients to manually enter information; others demonstrate more advanced functionalities, including digital approvals, uploading of existing information and options for patient and provider completion. As of November 2018, 14 states had some type of registry for completed advance directives (GAO, 2019).

While care coordination is always important to ensure that patients receive high quality care, the COVID-19 pandemic has highlighted gaps in care coordination. Patients may find themselves in the hospital unexpectedly as a result of COVID-19, making it essential that they have an advance care plan and that it is up to date (Curtis, Kross & Stapleton, 2020). Patients who end up in the hospital are often not allowed to have anyone accompany them, which further demonstrates the importance of having an advance care plan in place. But if organizations are unable to effectively document, share and coordinate this information across settings, it can lead to patients receiving care that is not concordant with their wishes (Paladino et al, 2020).

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