Proposed Indicator Retirement of Existing Measure for HEDIS®[1] MY 2025: Care for Older Adults (COA): Pain Assessment Indicator

NCQA seeks comments on the proposed retirement of the pain assessment indicator from the HEDIS *Care for Older Adults* measure. NCQA is proposing retirement of the pain assessment indicator for MY 2025. The potential retirement of this Medicare Star measure is being coordinated with the Centers for Medicare & Medicaid Services (CMS). NCQA is also exploring the development of a new chronic pain measure focused on older adults.

The COA pain assessment indicator, specified for individuals 65 years of age and older who are enrolled in a Special Needs Plan (SNP) or a Medicare-Medicaid Plan (MMP), requires at least one pain assessment be conducted during the measurement year. Several concerns have been identified with the existing pain assessment indicator that if left unaddressed, limit its ability to effectively drive care quality. Those concerns are described below.

Chronic Pain. The current pain assessment indicator does not differentiate between acute and chronic pain, which may have different causes and treatment plans.[2,3] There is no evidence that asking someone annually about pain, without a clinical indication that acute or chronic pain is occurring, will initiate appropriate pain management and improve quality of care.

Multidimensional Assessment. The current pain assessment indicator does not guarantee use of a multidimensional assessment. Rather, the indicator allows the use of many different types of assessments, including both unidimensional and multidimensional assessments. Unidimensional assessments focus on quantifying the intensity of a patient's pain at a point in time. Multidimensional assessments take a more holistic look at a patient's pain and assess its impact on the patient's physical and mental health, functionality, and other psychosocial factors. The use of multidimensional pain assessment tools can increase the likelihood of identifying a specific diagnosis, aid in selecting the most appropriate pharmacological and nonpharmacological interventions for pain relief and guide the selection of treatments in accordance with the needs and preferences of patients.[4]

Follow-up. The current pain assessment does not assess whether follow-up after assessment even occurs. Appropriate follow-up is a crucial component of pain management and should take a multidimensional approach. Ensuring that the individual receives sufficient follow-up care once chronic pain has been identified can help shift the focus from pharmacological and interventional treatment to self-management of pain over the long term and achievement of higher levels of functioning and quality of life, even if pain remains.[5]

NCQA seeks feedback on following questions:

1. Do you support retirement of the pain assessment indicator for HEDIS MY 2025?
2. If the indicator is retired, should NCQA explore and develop a pain-focused measure that incorporates the elements above?

Supporting documents include the current measure specification, evidence workup and performance data.

NCQA acknowledges the contributions of the Geriatric Measurement Advisory Panel and the Pain Expert Work Group.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] Cleveland Clinic. (2020). Acute pain vs. Chronic pain: Differences & causes. https://my.clevelandclinic.org/health/articles/12051-acute-vs-chronic-pain
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Care for Older Adults (COA)

SUMMARY OF CHANGES TO HEDIS MY 2025

- Removed the Pain Assessment indicator.

Description

The percentage of adults 66 years of age and older who had each of the following during the measurement year:

- Medication review.
- Functional status assessment.

Definitions

Medication list	A list of the member's medications in the medical record. The medication list may include medication names only, or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
Medication review	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.
Standardized tool	A set of structured questions that elicit member information. May include person-reported outcome measures, screening or assessment tools or standardized questionnaires developed by the health plan to assess risks and needs.

Eligible Population

Product line	A review of all member medications, including prescription medications, OTC medications and herbal or supplemental therapies.
Product line	Medicare (only SNP and MMP benefit packages).
Ages	66 years 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 during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

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Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 15: Members in Hospice*.
- Members who died any time during the measurement year. Refer to *General Guideline 16: Deceased Members*.

Administrative Specification

Denominator

The eligible population.

Numerators

Medication Review

Either of the following meets criteria.

- Both of the following during the same visit during the measurement year where the provider type is a prescribing practitioner or clinical pharmacist:
  - At least one medication review (Medication Review Value Set).
  - The presence of a medication list in the medical record (Medication List Value Set).
- Transitional care management services (Transitional Care Management Services Value Set) during the measurement year.

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Functional Status Assessment

At least one functional status assessment (Functional Status Assessment Value Set) during the measurement year. Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

~~***Pain Assessment***~~

~~At least one pain assessment (Pain Assessment Value Set) during the measurement year. Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).~~

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

No numerators?

Medication Review

- At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year ***and*** the presence of a medication list in the medical record, as documented through either administrative data or medical record review.
- A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

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Medical record

Documentation must come from the same medical record and must include one of the following:

- A medication list in the medical record ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

Functional Status Assessment

At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®.
  - Assessment of Living Skills and Resources (ALSAR).
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
  - Bayer ADL (B-ADL) Scale.
  - Barthel Index.
  - Edmonton Frail Scale.
  - Extended ADL (EADL) Scale.
  - Groningen Frailty Index.
  - Independent Living Scale (ILS).
  - Katz Index of Independence in ADL.
  - Kenny Self-Care Evaluation.
  - Klein-Bell ADL Scale.
  - Kohlman Evaluation of Living Skills (KELS).
  - Lawton & Brody's IADL scales.

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- Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales.

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits in the measurement year. Do not include comprehensive functional status assessments performed in an acute inpatient setting.

~~***Pain Assessment***~~

~~At least one pain assessment during the measurement year, as documented through either administrative data or medical record review.~~

~~**Administrative**~~

~~Refer to *Administrative Specification* to identify positive numerator hits from administrative data.~~

~~**Medical record**~~

~~Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.~~

~~Notations for a pain assessment must include one of the following:~~

- ~~Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).~~
- ~~Result of assessment using a standardized pain assessment tool, not limited to:~~
  - ~~Numeric rating scales (verbal or written).~~
  - ~~Face, Legs, Activity, Cry Consolability (FLACC) scale.~~
  - ~~Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).~~
  - ~~Pain Thermometer.~~
  - ~~Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).~~
  - ~~Visual analogue scale.~~
  - ~~Brief Pain Inventory.~~
  - ~~Chronic Pain Grade.~~
  - ~~PROMIS Pain Intensity Scale.~~
    - ~~Pain Assessment in Advanced Dementia (PAINAD) Scale.~~

~~Do not include pain assessments performed in an acute inpatient setting.~~

Note

- ~~*Notation alone of a pain management plan does not meet criteria.*~~
- ~~*Notation alone of a pain treatment plan does not meet criteria.*~~
- ~~*Notation alone of screening for chest pain or documentation alone of chest pain does not meet criteria.*~~
- *Refer to Appendix 3 for the definition of clinical pharmacist and prescribing practitioner.*
- *A medication review performed without the member present meets criteria.*
- *The Functional Status Assessment ~~and Pain Assessment~~ indicator~~s~~ do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.*

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Data Elements for Reporting

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

Table COA-3: Data Elements for Care for Older Adults

Metric	Data Element	Reporting Instructions	A
MedicationReview	CollectionMethod	For each Metric	✓
FunctionalStatusAssessment	EligiblePopulation*	For each Metric	✓
~~PainAssessmen~~	ExclusionAdminRequired*	For each Metric	✓
	NumeratorByAdminElig	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the Administrative Method.

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Care for Older Adults: Pain Assessment

Measure Workup

Topic Overview

Chronic pain is defined by the National Center for Complementary and Integrative Health (2018), part of the National Institutes of Health, as "pain that lasts more than several months (variously defined as 3 to 6 months, but longer than "normal healing")." Chronic pain is prevalent across adults in the U.S., and is especially prevalent among adults over the age of 65. Chronic pain can lead to negative health outcomes, including risk for premature death, and may cost the health care system up to $635 billion annually. The complexity of chronic pain makes effective management difficult, particularly in the primary care setting. Because the U.S. had fewer than 6,000 pain management specialists as of 2020, individuals frequently receive pain management from their primary care practitioner, who may lack the time, expertise and resources required for proper pain assessment and management.

Chronic pain may affect all aspects of an individual's life, including both their physical and mental health. In recent studies, individuals have noted the difficult-to-describe, multidimensional negative effects of chronic pain. These studies found chronic pain interfered with physical function, job life, family life and relationships, social life, sleep and mood (Hadi et al., 2018; Kawai et al., 2017). Although there are several barriers to managing chronic pain, including lack of clear consistent guidance and gaps in reimbursement for certain nonpharmacological treatments, using a multidimensional pain assessment can help identify interference in these areas of an individual's life and increase the likelihood of identifying a specific diagnosis. It can also help providers identify the most appropriate intervention for the patient's pain and guide selection of interventions in accordance with their needs and preferences (Scher et al., 2020).

Importance and Prevalence

Chronic pain is among the most common reasons people seek medical care, and it has significant consequences in the U.S. and worldwide (Dahlhamer et al., 2018). Based on findings from the 2019 National Health Interview Survey (NHIS) it is estimated 30.8% of adults 65 years of age and older experience chronic pain, and 11.8% experienced chronic pain that limited life or work in the last 3 months (Zelaya et al., 2020). Chronic pain is considered a risk factor for premature death, and may accelerate cognitive decline (Domenichiello & Ramsden, 2019). Dementia and cognitive decline may also impact an individual's ability to perceive and report pain, which can further complicate treatment decisions (Domenichiello & Ramsden, 2019). Severe chronic pain unduly affects those of lower socioeconomic status and education levels. These patients are more likely to experience a lower quality of care due to several factors, including limited access to treatment, provider difficulty understanding the patient's pain severity and misaligned expectations between provider and patient (Bifulco et al., 2021).

Supporting Evidence

Financial importance and cost-effectiveness	It is estimated that costs attributable to chronic pain in the U.S. range from $560 to $635 billion annually (U.S. Department of Health and Human Services (HHS), 2019). In 2016, it was estimated that chronic low back and neck pain alone accounted for $134.5 billion in health care expenditures, of which 30.3% was attributed to Medicare members (Dieleman et al., 2020). NCQA found gaps in access and coverage for nonpharmacological treatments when interviewing providers, pain clinics and health plans in 2019 (National

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Committee for Quality Assurance, 2020). Further, a 2019 report published by the U.S. Department of Health and Human Services (HHS), "Pain Management Best Practices Interagency Task Force Report," found that many insurances do not reimburse for behavioral pain treatments, or reimburse at a much lower rate than for pharmacologic or interventional treatments (HHS, 2019). These reimbursement issues, in combination with a shortage of pain management specialists, place a burden on under-resourced primary care physicians, further hindering the development of cost-effective health care delivery models to treat chronic pain (HHS, 2019).

Relationship to outcomes

Multidimensional assessment and treatment are the most effective approaches for older adults to manage pain (Booker, Herr & Horgas, 2021). This type of approach moves beyond an indication or rating of pain severity by including assessment of function, pain levels during movement, biopsychosocial factors and individuals' goals (HHS 2019; Booker, Herr & Horgas, 2021). It also gives the provider a more holistic view of the individual's situation, allowing them to identify the most appropriate treatment plan. When a provider does not take this approach, key information about the individual's pain may not be identified and may limit the effectiveness of the assessment (Booker, Herr & Horgas, 2021). A comprehensive pain assessment can improve the chances of identifying a specific diagnosis for an individual's pain, point clinicians to treatments most likely to benefit the individual and identify targets for intervention (Reid et al., 2015).

Treatment of chronic pain should also take a multidimensional approach. While pharmacological treatment can be an important aspect of care, research has shown that nonpharmacological interventions such as physical therapy, cognitive behavioral therapy, mindfulness-based stress reduction and chiropractic treatment can be effective in improving chronic pain. The use of nonpharmacological interventions can help individuals by promoting self-efficacy, active problem solving, realistic goal setting and a functional rehabilitative outlook for the individual (Becker et al., 2017). Further, ensuring that the individual receives sufficient follow-up care once chronic pain has been identified can help shift the focus from pharmacological and interventional treatment to self-management of pain over the long term, and achieving high functioning and quality of life even if pain remains (Gauntlett-Gilbert & Brook, 2018).

Health care disparities

Relative to White Americans, Black Americans are more likely to be undertreated for pain (Hoffman et al., 2016; Knoebel, Starck & Miller, 2021). Implicit bias, in addition to the subjective nature of pain and the clinician's need to rely on a patient's subjective report during pain assessment, may also contribute to undertreatment of Black patients (Mathur et al., 2014; Knoebel, Starck & Miller, 2021). A review found that Black patients are more likely to receive treatment that goes against guidelines. For example, they are less likely to receive opioids for acute pain and more likely to receive them for chronic pain. Additionally, they are less likely to receive a high-risk medication (e.g., opioids) for their pain because of fear of misuse, a fear that is contradicted by opioid abuse statistics (Knoebel, Starck & Miller, 2021).

Prevalence of chronic pain is higher among women (Zelaya et al., 2020). Despite this, there are gender biases in pain estimation and treatment (Kiesel, 2017; Samulowitz et al., 2018). Women are more likely to be given sedatives than pain medication. Additionally, one study found that women in an

emergency room with abdominal pain waited an average of 16 minutes longer for pain medication than their male counterparts (Kiesel, 2017).

Severe chronic pain disproportionately affects those with low socioeconomic status, less than a high school education and Medicaid health insurance (Dahlhamer et al., 2018). This group of patients has increased vulnerability to chronic pain, and may experience diminished quality of care due in part to limited access to treatment, misunderstanding or misinterpretation of pain severity and misaligned expectations between patients and health care professionals about pain treatment, function and quality of life (Dahlhamer et al., 2018; Ly, 2019; Shavers et al., 2010; Janevic et al., 2017).

Gaps in care

There is a need for more pain specialists in the U.S. Between 2011 and 2020, only 3,237 providers across six specialties received certification in the subspeciality of pain medicine from the American Board of Medical Specialties. Of half those specialties (family medicine, emergency medicine, radiology), fewer than 20 providers subspecialized in pain medicine (American Board of Medical Specialties, 2021). Further, the American Board of Pain Medicine (n.d.) stated that as of June 2020 it had certified only around 2,200 providers.

Given the limited number of pain specialists, primary care physicians are often tasked with addressing patients' pain, often without the necessary training, time or resources. This signals both the need for more pain management specialists and processes, and for workflows that allow primary care physicians the time and resources to adequately assess and address their patients' pain (HHS, 2019).

In its 2019 report, HHS highlighted gaps both in provider and patient knowledge regarding pain management. For providers, the report highlights a need for education throughout the health care provider community for both acute and chronic pain, from professional school curricula to post graduate education and further clinical specialty training. The report also noted a need for additional education on pain as a category of disease, rather than as a symptom of another illness. The report noted patient educational gaps, including lack of knowledge about acute and chronic pain, and that educational materials and interventions for patients with chronic pain lack consistency, standardization and comprehensive information (HHS, 2019).

Policy and Payment

The referenced 2019 HHS report highlights best practices in pain management, and emphasizes the importance of individualized, patient-centered care in the diagnosis and treatment of acute and chronic pain (HHS, 2019). The Task Force identified risk assessment as one of four cross-cutting policy approaches needed to provide individualized, patient-centered care. Risk assessment includes a thorough patient assessment and evaluation for treatment, and incorporates a risk-benefit analysis for each patient. Identifying risk factors from patient history, family history, current biopsychosocial factors and screening and diagnostic tools, including prescription drug monitoring programs, laboratory data and other measures, are all components of risk assessment. Risk stratification can assist in determining appropriate treatment for the best clinical outcomes (HHS, 2019). The report acknowledges the lack of coverage for pain management and treatment, and recommends that CMS and other payers develop appropriate reimbursement policies for pain management and treatment. It also acknowledges inconsistencies and frequent delays in coverage for nonpharmacologic and interventional pain techniques that are clinically appropriate, and urges

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CMS and other payers to provide consistent and timely coverage for evidence-informed pain procedures (HHS, 2019).

In recent years, there have been no significant updates to general guidelines or recommendations related to pain assessment. Although the 2019 HHS report identifies gaps and offers recommendations, it does not provide firm clinical guidance (HHS, 2019). The CDC is currently updating its 2016 Clinical Practice Guideline for Prescribing Opioids, but the new guidance focuses largely on opioids and does not appear to provide specific guidance on general pain assessment (Federal Registrar, 2022). Some organizations that were previously thought to be authorities on pain have now reversed guidance, have not updated their guidance or have since been dissolved (Booker, Herr & Horgas, 2021; American Academy of Pain Medicine, 2019).

Care Coordination

Pain management benefits from interdisciplinary, collaborative work. Many medical settings do not have the type of integrated care necessary to effectively treat patients with chronic pain, and primary care physicians (PCP) are frequently relied on for pain management (Midboe et al., 2011, Harle et al., 2015, HHS 2019). The average primary care visit in the U.S. is between 15 and 20 minutes, resulting in a negotiation and balance between what the PCP believes is essential and what the patient wants to discuss (Irving et al., 2017, Bifulco et al., 2021). Having to readdress and rediscuss pain can result in frustration and dissatisfaction for clinicians, and may largely be a consequence of a health care delivery system that is still based on short, in-person visits and high-volume, fee-for-service encounters (Bifulco et al., 2021).

Since the onset of the COVID-19 pandemic, there has been increased use of telehealth, including for assessment and treatment of chronic pain. However, there is a lack of suggested best practice approaches for the utilization of telehealth in chronic pain assessment and treatment (Emerick et al., 2020). The risks for pain assessment and treatment when using telemedicine are especially high for patients at risk for opioid misuse, addiction or overdose, and for patients with acute pain, unclear diagnosis and medical or psychosocial complexity (Emerick et al., 2020). While telehealth may not be appropriate for all patients in need of assessment and treatment for chronic pain, it may be helpful during transitions of care. For example, telehealth can help coordinate outpatient pain management care before a patient is discharged from a hospital or emergency room (Emerick et al., 2020).

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HEDIS Health Plan Performance Rates 2019—2022: Care for Older Adults—Pain Assessment Indicator

Table 1. HEDIS Care for Older Adults—2022 Pain Assessment Measure Performance—Medicare Plans (SNP & MMP only)

Measurement Year 2022	Number of Plans Reporting (N)	Percentage of Plans Reporting (%)	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Admin	51	6.4	85.3	30.2	29.6	96.1	99.0	99.6	100.0
Hybrid	749	93.6	91.8	9.1	81.1	88.7	94.9	97.8	99.0
Total	800	100.0	91.3	11.7	80.8	88.8	95.3	98.0	99.3

*In 2022 the average denominator across plans was 2,993 individuals, with a standard deviation of 6,210.

Table 2. HEDIS Care for Older Adults—2021 Pain Assessment Measure Performance—Medicare Plans (SNP & MMP only)

Measurement Year 2021	Total Number of Plans (N)	Percentage of Plans Reporting (%)	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Admin	36	5.2	91.2	21.4	75.0	96.6	99.3	100.0	100.0
Hybrid	656	94.8	91.3	9.8	79.6	88.3	94.7	97.8	99.5
Total	692	100.0	91.3	10.7	79.3	88.6	94.9	98.1	99.8

Table 3. HEDIS Care for Older Adults—2019 Pain Assessment Measure Performance—Medicare Plans (SNP & MMP only)

Measurement Year 2019	Total Number of Plans (N)	Percentage of Plans Reporting (%)	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Admin	21	3.7	85.9	24.5	65.6	86.4	96.4	98.6	99.2
Hybrid	551	96.3	92.6	10.1	81.0	90.6	96.6	98.5	99.5
Total	572	100.0	92.4	11.0	80.8	90.6	96.6	98.5	99.5

[1]HEDIS MY 2020 Medicare data were not publicly reported due to the COVID-19 pandemic.

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