Meeting Summary

Core Quality Measures Collaborative Medical Oncology Workgroup Meeting

Under its Partnership for Quality Measurement (PQM), Battelle convened the Core Quality Measures Collaborative (CQMC) Medical Oncology Workgroup on Tuesday, November 12, 2024, to discuss potential measure additions to or measure removals from the Medical Oncology core set.

Welcome and Opening Remarks

Kate Buchanan, MPH, Battelle CQMC lead, welcomed workgroup members to the Medical Oncology meeting to discuss core set updates. Ms. Buchanan informed workgroup members that Battelle now holds the Centers for Medicare & Medicaid Services (CMS) consensus-based entity (CBE) contract, which was formerly held by National Quality Forum (NQF). She reviewed the anti-trust compliance statement and reminded members that CQMC is a membership-driven and -funded effort, with additional support from CMS and AHIP.

Ms. Buchanan introduced the workgroup co-chairs, Bryan Loy, MD, and John Cox, DO, FASCO, MACP, MBA, and provided a list of voting and non-voting members. Both co-chairs welcomed everyone to the meeting and encouraged members to consider how the health care landscape has evolved since the last Medical Oncology Workgroup meeting in 2020.

Ms. Buchanan then outlined the core set maintenance process, noting the intent of the core sets is to be used in value-based programs, the CQMC measure-selection principles in the core set, and the core set maintenance process. Ms. Buchanan added that maintenance ensures that each specialty-specific core set reflects current CQMC priorities and measure selection criteria.

2020 Maintenance Review Recap

Ms. Buchanan provided a high-level recap of the measures under review and results from the 2020 cycle. During the 2020 cycle, the workgroup recommended the removal of three measures:

- CBE #1857 HER2 negative or undocumented breast cancer patients spared treatment with HER2-targeted therapies
- CBE #1853 Radical Prostatectomy Pathology Reporting
- CBE #0211 Proportion of patients who died from cancer with more than one emergency room visit in the last 30 days of life

The workgroup discussed the American Society of Clinical Oncology's (ASCO) 2017 report and ASCO/the American Board of Internal Medicine's (ABIM) Choosing Wisely list and agreed that the information from the report are still gap areas. The workgroup also identified patient experience as an important topic that remains a gap area and discussed how difficult it is to quantify patient experience for oncology and the increased burden on providers to include patient experience in their workflows. Additionally, the workgroup discussed ways to capture information without adding burden to patients, including reaching out in a timely fashion to assess symptoms, obtaining more detailed information about patient experience, and adding questions about experience to existing instruments. Members gave updates on ASCO and CMS measures and expressed interest in moving in the direction of more future-focused measurement.

The Current Core Set

Ms. Buchanan provided an overview of the current Medical Oncology core set, noting that it has 17 measures: 11 process, two outcome, two intermediate outcome, and two patient-reported outcome-based performance measures (PRO-PMs).

Measures for Consideration – Addition

Ms. Buchanan reviewed the factors to consider for additions to the core set. She noted that Battelle conducted an environmental scan using a 5-year lookback period. The sources for the scan included:

- CMS Measures Inventory Tool (CMIT)
- CMS Measures Under Consideration (MUC) Entry/Review Information Tool (MERIT)
- PQM Submission Tool and Repository (STAR)
- Measures mentioned in previous meetings
- Quality Payment Program (QPP)
- Healthcare Effectiveness Data and Information Set (HEDIS)

While developing the environmental scan, Battelle staff considered whether a measure met CQMC's principles for measures in the core set, if it addressed a key topic or gap area identified by the workgroup or had been recommended by a workgroup member. Battelle identified 17 measures for the workgroup to consider:

- Two on care coordination:
    - CMIT #710 Support Electronic Referral Loops by Sending Health Information
    - CMIT #709 Support Electronic Referral Loops by Receiving and Incorporating Health Information
- Three on biomarkers:
    - CBE #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma
    - MUC2023-161 Appropriate Germline Testing for Ovarian Cancer Patients
    - MUC2023-141 Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy
- Six PRO-PMs/symptom management:
    - CBE #3720 Patient Reported Fatigue Following Chemotherapy among Adults with Breast Cancer
    - CBE #3718 Patient Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer
    - CAHPS Cancer Care Survey
    - CMIT #1651 Appropriate intervention of immune-related diarrhea and/or colitis in

patients treated with immune checkpoint inhibitors
    - CBE #3665 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
    - CBE #3666 Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain
- One prostate cancer:
    - CMIT #714 Surgical Treatment Complications for Localized Prostate Cancer Measure
- One pain:
    - CBE #0383 Oncology: Medical and Radiation-Plan of Care for Moderate to Severe Pain
- One behavioral health:
    - CBE #0028/0028e Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Three social determinants of health (SDOH):
    - CMIT #1662 Driver of Health Screen Positive Rate
    - CMIT #1664 Driver of Health Screening Rate
    - Social Need Screening and Intervention (SNS-E)

Discussion about care coordination measures:

- *CMIT #710 Support Electronic Referral Loops by Sending Health Information*
- *CMIT #709 Support Electronic Referral Loops by Receiving and Incorporating Health Information*

The developer was present for the discussion but replied to the workgroup's inquiries in writing following the meeting. The workgroup noted how both measures (CMIT #709 and CMIT #710) address the gap in care coordination and were interested in the effectiveness and performance data of the measures in other programs. One workgroup member commented on the technical feasibility of the measures across all health systems in the country and whether it created gaps in care. The developer replied that all certified electronic health record (EHR) technology must provide this functionality as these are required measures. Another member raised concerns around the impact on community care settings as many groups use different EHR systems and some have not transitioned to using EHRs at all. The workgroup asked for clarification on whether the responsibility of providing the summary report falls to the referring entity or the recipient entity, as well as if various services are provided in different locations. The developer replied that for CMIT #710, the Merit-based Incentive Payment System- (MIPS) eligible clinician who transitions or refers their patient to another setting of care or health care provider creates a summary of care record using certified electronic health record technology (CEHRT) and electronically exchanges the summary of care record. For CMIT #709, the MIPS-eligible clinician who was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS-eligible clinician has never before encountered the patient, the MIPS-eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list. AHIP asked if there would be systems for clinicians to report the measure outside of the Medicare Promoting Interoperability (MIPS) program. Because CEHRTs require these reporting fields, others outside of MIPS can report on it.

Discussion about biomarker measures:

- *CBE #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma*
- *MUC2023-161 Appropriate Germline Testing for Ovarian Cancer Patients*
- *MUC2023-141 Positive PD-L1 Biomarker Expression Test Result Prior to First-Line Immune Checkpoint Inhibitor Therapy*

A co-chair mentioned that all three measures are significant parts of practice. The measure steward of CBE #3661 is mostly geared toward pathologists and suggested that those clinicians should order this testing but only in consultation with oncologists.

A co-chair asked about the methodology for the PD-L1 testing in MUC2023-141, specifically the Tumor Proportion Score (TPS) vs Combined Positive Score (CPS) variation of drugs brought to market. The steward responded that the U.S. Food and Drug Administration (FDA) approved indications for single agent inhibitors that require PD-L1 testing prior to administration and those have specific cut points for testing. Another measure steward mentioned that they specifically avoided stating any cutoff points to ensure the measure stood the test of time as more information was gathered. The steward said that MUC2023-161 is focused on breast cancer (BRCA) gene 1 and BRCA 2 and is currently in use in MIPS.

Discussion about patient-reported outcome performance measures (PRO-PM)/ symptom management:

- *CBE #3720 Patient Reported Fatigue Following Chemotherapy among Adults with Breast Cancer*
- *CBE #3718 Patient Reported Pain Interference Following Chemotherapy among Adults with Breast Cancer*
- *CAHPS Cancer Care Survey*
- *CMIT #1651 Appropriate intervention of immune-related diarrhea and/or colitis in patients treated with immune checkpoint inhibitors*
- *CBE #3665 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood*
- *CBE #3666 Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain*

The measure steward for CBE #3720 and CBE #3718 noted that both measures have undergone and received CBE endorsement. The steward added that the measures are risk adjusted for age, gender, race/ethnicity, smoking status, and surgical history. The intent of the measures is to decrease the burden of patients' symptoms. A workgroup member asked for clarification on how the information would be useful to health plans. The steward replied that the data from the measure would provide insight into which clinical oncologists are helping patients manage the persistence of their symptoms. The workgroup also discussed the potential burden of implementing the Patient-Reported Outcomes Measurement Information System (PROMIS) scale into clinical practices that are not currently using that scale. The measure steward stated that the technical expert panel (TEP) had 12 oncologists on the panel, and most were not using PROMIS. However, the patient group evaluated the question items and found it useful.

The measure steward for CMIT #1651 noted that this measure fills a gap in identifying adverse events associated with immunotherapy and is currently in use in the MIPS program and the

Oncology Care Measure Value Pathways. They expect to have implementation data in the next year. The workgroup discussed how adverse events are graded, and the steward replied that they developed the measure to educate clinicians. The workgroup also discussed the measure implementation and relevance.

The measure steward for CBE #3665 and CBE 3666 said that both measures are CBE endorsed and utilized a technical expert clinical user patient panel (TECUPP) to include patient voices in the development process.

The workgroup also discussed how inclusion of CBE #3661 would contradict previous decisions from the workgroup, specifically concerning measures for reporting by pathologists. Previously the workgroup voted to remove CBE #1853 Radical Prostatectomy Pathology Reporting because the pathologist reported the measure, and the workgroup agreed pathology fell outside of the core set criteria. A co-chair noted that although the pathologist reports the measure, the medical oncologist is responsible for understanding the results to make an effective treatment plan. He did note that while some institutions adopt a policy in pathology to test straight away, we are entering a new treatment era in targeted therapies where specific genetic or biomarker tests are needed to make treatment decisions. The workgroup agreed to provide feedback on the potential change to core set criteria.

Discussion about prostate cancer measure:

- *CMIT #714 Surgical Treatment Complications for Localized Prostate Cancer Measure*

The workgroup noted the value this measure (CMIT #714) would provide to patients researching prostate cancer treatments and the lack of burden in reporting. One member asked about the time window for assessing the complications of a prostatectomy.

Discussion about pain measure:

- *CBE #0383 Oncology: Medical and Radiation -Plan of Care for Moderate to Severe Pain*

CBE #0383 is a paired measure for one already included in the core set, CBE #0384 Oncology: Medical and Radiation – Pain Intensity Quantified. The measure steward mentioned that CMS requested they combine the measures, and they are currently discussing this internally. They added that CBE #0384 is an electronic clinical quality measure (eCQM), and, if the measures are combined, a potential risk is that the resulting measure may not be an eCQM. A co-chair suggested that executing any plan in a timely fashion would be a priority. The measure steward answered that the measures are intended to be recorded together, assess pain, and develop a plan for care.

Discussion about behavioral health measure:

- *CBE #0028/0028e Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*

CBE #0028/0028e is a crosscutting measure; the measure steward noted that smoking cessation is highly relevant, and that vaping is also a risk and should be considered once more data are available. A co-chair remarked that it would be good to know whether tobacco cessation was included in any of the core set measures and questioned the need to broaden the

category to vaping or cannabis. A workgroup member suggested adding an intervention requirement following a positive screen for tobacco use.

Discussion about SDOH measures:

- *CMIT #1662 Driver of Health Screen Positive Rate*
- *CMIT #1664 Driver of Health Screening Rate*
- *Social Need Screening and Intervention (SNS-E)*

Ms. Buchanan noted that all CQMC workgroups are considering these SDOH measures and that they are not specific to medical oncology. A workgroup member said that tying screening with intervention was important, and added that of the three measures, the Social Need Screening and Intervention (SNS-E) HEDIS measure is the most useful, but that all three serve a distinct purpose. A co-chair asked about the individual patient financial aspect of the measure and added that economic impact is very much connected to cancer care; he noted that economic challenges are correlated with poorer health outcomes. The workgroup discussed the challenges oncology staff have in addressing social needs. A workgroup member discussed the value of asking these difficult questions and trying to provide services to address them; however, the member noted that there are inherent challenges in the timing. They found that, for patients who are not low income at the beginning of treatment, financial distress due to cancer treatment occurs a couple of months into care. For patients who are low income at the beginning of treatment, these issues often get worse during care. The workgroup agreed that these measures are important and that work needs to begin somewhere.

In written follow-up, CMS provided additional detail on CMIT #1662 and #1664. The primary goal of the measures is to get all hospitals to collect patient-level social risk factor data to ensure collaboration between health care providers and community-based organizations. The identification of social risk factors helps clinicians and hospitals link with community-based organizations who can provide the patient with resources necessary for their treatment. CMS does not require hospitals to report any actions they engage in when reporting this measure. Hospitals should screen patients during every admission but only submit information for each unique person once during a reporting period. CMS allows hospitals flexibility with tool selection and does not require the use of specific questions.

Measures for Consideration – Removal

Ms. Buchanan reviewed the factors to consider for removal from the core set. She noted that Battelle reviewed the current core set looking for changes to endorsement status, changes in program use, and key topics identified by the workgroup. Ms. Buchanan stated that Battelle identified six measures for removal:

- CBE #0559 Combination chemotherapy or chemo-immunotherapy (if HER2 positive), is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0 or stage IB - III hormone receptor negative breast cancer
- CBE #0223 Adjuvant chemotherapy is recommended, or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer
- CBE #0389/0389e Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- CBE #0211 Proportion of patients who died from cancer with more than one emergency department visit in the last 30 days of life
- CBE #0215 Proportion of patients who died from cancer not admitted to hospice
- OCM-6 Patient-Reported Experience of Care (MIPS ID 1758)

Ms. Buchanan noted that the American College of Surgeons (ACS) stewards of CBE #0559 and CBE #0223 no longer participates in the CBE endorsement process.

A co-chair asked why the endorsement was removed for CBE #0389/0389e. Following the call, Battelle staff noted that the measure developer withdrew the measure from the endorsement process. A co-chair noted that as a clinician, he is still inclined to monitor for overuse of bone scan in CBE #0389/0389e even if the measure is removed from the core set. The measure steward mentioned that their measures were initially developed as registry measures and CMS has adapted them.

ASCO, the steward of CBE #0211 and CBE #0215, noted that they intend to work with CMS to align the measures as much as possible.

Gaps Discussion

Ms. Buchanan provided an overview of gap areas in measure development mentioned in previous workgroup meetings. The workgroup agreed to provide feedback on the gaps during voting.

Next Steps

Ms. Buchanan provided an overview of voting procedures. The voting link will be sent from CQMC@Battelle.org. Ms. Buchanan reminded the group of supermajority rules around voting and provided an overview of the Full Collaborative Approval process.