

## Meeting Summary

### Medical Oncology Workgroup Meeting #3

---

The National Quality Forum (NQF) convened a closed session web meeting for the Medical Oncology Workgroup on August 22, 2019.

#### Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff read the antitrust statement and reminded the Workgroup of the voluntary nature of the CQMC and the obligation of all participants to comply with all applicable laws. NQF staff notified Workgroup members that the meeting is being recorded for the purpose of accurately capturing the discussion for meeting minutes and to allow CQMC members to listen to the meeting for a limited time only. The recording will be destroyed as soon as reasonably practical. NQF staff reviewed the following meeting objectives:

- Discuss oncology core set framework
- Evaluate new measures for addition to the core set
- Evaluate current core set measures for potential removals

#### Decision-making Process

##### Voting and Quorum

NQF staff provided an overview of quorum and voting process. The Workgroup was informed that voting and non-voting participants could take part in discussion, but only voting participants would participate in the voting process. Quorum is defined as representation from at least one health insurance provider representative, at least one medical association representative, and at least one representative from the remaining voting participant categories (i.e., consumers, purchasers, regional collaboratives). NQF will send out a survey to voting participants after all measure discussions have taken place.

#### Medical Oncology Framework and Implementation Discussion

NQF staff summarized meeting #2 discussions and provided additional information eMeasures. The Workgroup has had several future-focused discussions about implementation and developing an ideal core set framework, which have occurred in parallel with core set maintenance activities. During the second meeting the Workgroup expressed the need to select measures that use available data, have the ability to be benchmarked, can influence provider care at the frontline, and consider the patient perspective. Workgroup members highlighted that core measures should be selected and aligned for use by the public and private payers because decreasing reporting burden is a main goal.

NQF staff shared that to promote alignment other CQMC Workgroups have supported the inclusion of eMeasure version of measures when available while noting that separate benchmarks may be needed based on reporting mechanism. As defined by NQF, an eMeasure (also known as eCQMs or

electronic clinical quality measures) is a measure that is specified in the accepted standard health quality measure format (HQMF) and uses the Quality Data Model (QDM) and value sets vetted through the National Library of Medicine's Value Set Authority Center (VSAC). Alternate forms of EHR specifications other than HQMF are not considered eMeasures by NQF.

A co-chair was interested in whether NQF had benchmarking data, implementation data, and impact on quality of care data available for all eMeasures. NQF staff stated one goal of using eMeasures is to reduce implementation issues around value sets and codes and harmonize reporting requirements. NQF staff acknowledged potential feasibility concerns given the current IT infrastructure and ability to share information. A co-chair expressed that it is vital to understand benchmarking data based on data sources, citing an example that a registry measure that appears to be topped out may reflect a different picture of performance when transitioned to electronic capture.

Workgroup members discussed that some HEDIS measure are being transformed to allow for more innovative data capture. The Workgroup continued to discuss that since payers may have difficulty capturing certain measures, for example those built for MIPS or a particular registry, CQMC work should explore how measures can be captured more broadly. A payer member expressed challenges with the ability to obtain certain data, especially staging data which is not available through claims. The Workgroup emphasized the importance of a long-term strategy for better IT integration. This would allow for an increased ability to understand measure results in real time and use results to drive quality improvement. Another member reiterated the challenges of utilizing retrospective data and the difficulty of not being able to affect quality of care in real time. Results based on a small volume of patients or insufficient data make it difficult to interpret results to improve quality. NQF staff agreed that these are appropriate challenges and noted that the CQMC will continue to work to address these areas of opportunity in measurement as well as focus specifically on implementation guidance.

NQF staff shared a few key points from the implementation survey from 2017, which demonstrated about 75% of plans surveyed were planning to adopt at least some core set measures. NQF staff stated data source challenges was identified as one of the top adoption barriers. A co-chair encouraged the Workgroup to explore "small steps" to address some of these data access issues as it will be counterintuitive to select measures that will not be implemented.

The Workgroup previously wanted to create a framework for the composition of the ideal medical oncology measure set to serve as a foundation for this effort as well as to guide future gap identification and expansion opportunities. This ideal "core set" would include concepts that could be applied across settings and levels of analysis and include patient-reported experiences (e.g., experience with care planning, decision-making, side effects). NQF staff shared ASCO's recommendations for a core set of performance measure to improve value in cancer care published in 2017 (developed through a multistakeholder meeting at least a year prior). These candidate measure topics will serve as a framework for the Workgroup to build upon.

Since 2017 there has been progress in developing and selecting meaningful measures that decrease burden; however, there are still barriers with data access and not enough patient-reported measures and outcome measures. Additionally, there is increased recognition that resource use is an issue. The Workgroup discussed that the measure environment has changed, and there is a need to re-evaluate the best core measure currently available as well as determine what the deal state of measurement should be. A co-chair agreed with these remarks, stating that these frameworks are vital, but it is also important to understand how to gather the data and how it can be given to providers. A member expressed that organizations receive feedback from providers expressing willingness and interest in measuring and improving the quality of care, but highlight the challenges they encounter collecting

and interpreting the information. It was shared that practitioners involved in the OCM are currently facing these challenges.

A member responded to the ASCO recommendation list by sharing that emphasis should be placed on Emergency Room (ER) hospitalizations, avoidable short stay hospitalizations and addressing the root cause of those hospitalizations, primary care, disease progress, and pain management. At least one member stated that the ER care measure concept is valuable, although some may consider it a cost measure versus a quality measure. The member also expressed that measures on hospice care at the end of life are valuable, but conveyed concerns of small sample sizes and inability to draw conclusions. A co-chair expressed end of life care is of interest to private payers who are working internally to generate information and measures based on Medicare Advantage carve-ins.

Workgroup members emphasized that access to data, volume of data, and lack of interventions to improve quality were the most critical limitations. For example, patients may switch jobs and insurance plans and the insurance identification does not transfer or allow providers to understand a patient's history or current treatment. Both providers and plan members expressed difficult tracking patients. A member stated they have the same concern with tracking patients in hospice care and that they also do not have access to death data. A member noted their plan tried using the ER utilization measure as a proxy for coordination of care but faced challenges since there is no time stamp associated with the service.

NQF staff asked if there are any measures that members have had success using. A member said that they use total cost of care measures, which are especially useful if there are pharmacy benefits assigned to the member under the same payer. A co-chair asked how plans address new technology and high-cost drugs when considering total cost. Workgroup members responded that there are processes to be responsive to new to market drugs, but when benefits are fragmented it is harder to measure. It was discussed that plans look for practice variation on stable medications and year over year opportunity marks like high quality, low toxicity, high member convenience, and least costly alternative. A co-chair added that providers cannot control drug prices so it is challenging for medical oncologists to benchmark from a medication perspective. The most expensive drug might be the best drug for certain cancer types and providers should not be penalized for selecting such a medication. Providers can use the current guidelines to make decisions and elevate the standard of care and should be measured in these areas, which they can more directly influence. It was discussed that there is a need to measure quality of oncology care along with cost.

Regarding the framework of core concepts, a co-chair commented that the appropriate use of antineoplastic therapy is broad and that appropriate use guidance can change within six months based on new evidence and standards, making it challenging to benchmark. Triaging, symptom management and coordination of care are main components of ASCO's new alternative model of care. Workgroup members expressed that unfortunately it is easier to find out when care is not well coordinated than when it is coordinated, but were interested in coordination of care as a measure concept.

The Workgroup discussed patient reported outcome measures, especially perception of care and controlling pain. Workgroup members responded stating that patient-reported outcomes are a priority for their plans and they are trying to find ways to capture this information but have not been very successful to this point. Workgroup members also emphasized there aren't standard patient reported outcomes tools except Press Ganey surveys. It is challenging to get specific patient reports from these surveys because they are all grouped together. A member explained that if patients tell payers in real time about unmet needs, there is an opportunity to make change but when looking at metric patterns providers have to consider many different factors (e.g., data completeness, timing

relative to last visit). It was noted this is complex and not easily obtained from provider documentation. Another Workgroup member added that pain management questions on HCAHPS are systematically being removed. Though facility level measures, it was thought that the measures may place pressure on physicians to prescribe opioids. Another member added that there is a better way to phrase perception of pain that how it is phrased in HCAHPS. A co-chair added that there are oncologists who do not prescribe opioids for fear of addiction and refer these patients to a pain specialist. Workgroup members highlighted that Part D and MA programs have opioid prescribing limits on dosages and time frame.

A Workgroup member expressed that CMS has signaled a shift through MIPS Values Pathway, bundling measures that reflect an episode of care. Another member shared that plans do not necessarily have to create new measures, but it is very individualistic making it more tailored towards continuum of care and episodes of care. The Workgroup will revisit the ideal core set framework in the future.

### **Discussion on Current Measures in Core Set**

NQF staff provided a brief overview of current measures in the core set. NQF staff explained the group will vote on measures for addition and removal after measure conversations have taken place. NQF staff reported the current structure of medical oncology core set is 14 measures in the domains of breast cancer, colorectal cancer, prostate cancer, and hospice/end of life care. NQF staff added that the group should primarily focus on measures at the clinical-level, but that facility level measures have been included in some cases based on lack of measures available to fit key areas.

The Workgroup mentioned that related to the colorectal cancer measures that rectal cancer is treated differently from colon cancer and that perhaps these should be different categories. NQF staff acknowledged this comment and stated that although the category title is colorectal cancer, the scope of this Workgroup is on medical oncology. A Workgroup member who was involved in the previous CQMC work stated that the focus is slightly different from the previous group because there was not much focus on a particular level of measurement. The member emphasized that some clinician level measures were not selected because the Workgroup at that time had already selected a similar facility measure.

The Workgroup wanted to briefly discuss a few measure that were discussed in 2016 but not selected. A member reiterated that payers do not have access to 0386: Oncology: Cancer Stage Documented and reiterated that they do not have access to staging data. If payers cannot understand the cancer stage, many of the measures are of no value. Promoting transfer of staging information should be a prerequisite for most of the measures. NQF staff asked if other members agreed the measure should be prioritized. A co-chair explained that ASCO has advocated for this measure for a long time, but CMS rejected it because it is not a “true measure”. There was general agreement that many measures cannot be used without staging information. The Workgroup discussed that measure 0386 has been removed from MIPS and is no longer being maintained, but that the ACSO QOPI program has many similar measures that continue to be used. NQF staff acknowledged that this measure should be voted on by the Workgroup and will review if a similar measure is being maintained.

A member stated that measure 0219: Post breast conservation surgery irradiation is interesting, but asked if the focus should be on medical oncology services (rather than radiation oncology). NQF staff clarified that the scope is medical oncology, however there is an opportunity to expand to other areas in the near future. A member referenced measure 1853 Radical Prostatectomy Pathology Reporting, stating it would be more appropriate for a urologist. A member inquired if appropriate molecular testing, EGFR for non-small cell lung cancer is an existing quality measure, stating that as a payer the

measure is of interest but not easy to understand from claims. The member added that their organization is interested in understanding if a particular test is beneficial or harmful to a patient. Another member responded stating that these measures exist as individual biomarkers in registry data in the College of American Pathology QCDR. A member inquired if there is a directory or inclusive list of registry measures so payers can understand what measures exist. NQF staff added that the CQMC aims to select measures which are publicly available and accessible to be used. There was some discussion that QCDR information is publicly available as CMS hosts QCDR information.

Workgroup members also inquired about NQF incubator activities on biomarkers. NQF staff will check in on progress and follow-up with additional information.

### **Evaluation of Measures for Potential Addition**

*0220: Adjuvant hormonal therapy is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor-positive breast cancer*  
NQF staff shared this measure was discussed during the 2015/2016 CQMC work, and at that time the Workgroup agreed to discuss the measure during the next iteration. This measure is tested at the facility level. It is stewarded by the American College of Surgeons and used in Hospital Compare, Pennsylvania Health Care Quality Alliance for Public Reporting, Commission on Cancer (accreditation, benchmarking); and Quality Oncology Practice Initiative (QOPI) Certification Program.

A co-chair expressed that from a payer perspective, this is challenging to collect from claims data but from a clinical perspective there is probably a high percentage of providers who are practicing at this level. A member questioned if this measure would drive meaningful quality improvement. NQF shared that data from 2012 show average hospital performance 85% with a standard deviation of 19%. Based on 2012 information it seemed that the measure may indicate high performance for some cancer centers, but that gaps might persist among other hospitals. NQF staff stated that during meeting #2, Workgroup members had concerns about feasibility and impact on quality of care. Workgroup members inquired if there is a way for payers to know, outside of pre-op questionnaires, about hormone receptor status of the patients with early stage breast cancer. A co-chair expressed challenges of obtaining this information and felt the performance gap was likely small. Workgroup members agreed to remove this measure from consideration.

#### *0383: Plan of Care for Pain—Medical Oncology and Radiation Oncology*

NQF staff shared that there was brief discussion about this measure during the last call. NQF staff highlighted the measure description and specifications. The measure is tested at the clinician group and individual clinician level and used in ASCO's QCDR and MIPS (paired with measure 0384). Workgroup members stated this is a great measure, but because it is a care plan it is hard to capture electronically as a discreet data field. For measure 0384, there is a specified field capturing pain level. It was shared that the developer is working to modify the measure to respond to that challenge. A member inquired if there is a way to see if this was assessed over a time period. The developer explained the specifications have been updated from the version presented. The developer stated that presently, these are the specifications that exist for 2019 MIPS, but they are working with CMS to change the specifications for 2020. The Workgroup agreed that for a core measure there are too many challenges to collecting this information at this time. The Workgroup agreed to remove this measure from consideration.

#### *0385/0385e: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients*

NQF staff highlighted that this measure is tested at clinician group and individual clinician level. A member who is the developer explained that there was a similar facility-level measure which 0385 is harmonized with which was selected instead. As a result, 0385 was removed from PQRS and is no longer in MIPS, but the measure continues to be stewarded and was recently transitioned to ASCO. A

version of this measure still exists in QOPI, but not in a payment program. A co-chair added this measure also requires staging information and that therapy should be given within four months. The Workgroup agreed to remove this measure from further consideration.

The Workgroup continued to discuss the importance of having staging data in order to implement many of the proposed quality measures. Workgroup members stated that in lieu of staging data, measures may assess patient awareness of whether they are being treated for cure or quality of life or shared decision-making discussions about goals of care. ASCO QOPI has a measure about intent of care, but not about care goals. NQF staff emphasized the need to stay future focused, but also work to select the best measures that currently exist. A co-chair stated the focus should be on true quality versus quantity when updating the core set up; the Workgroup should only select measure that are most meaningful. It may be valuable to explore ways to adapt the current core set and measures under consideration to improve their ability to be used.

### **Next Steps**

During the next meeting the Workgroup will continue to discuss core set maintenance. Future work will involve implementation strategies and prioritizing measure gap areas.