

## NCCN POLICY SUMMIT SUMMARY

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### Defining, Measuring, and Applying Quality in an Evolving Health Policy Landscape and the Implications for Cancer Care

#### Overview

The [National Comprehensive Cancer Network \(NCCN\)](#) hosted a policy summit on September 12, 2019, in Washington, DC, presenting diverse perspectives related to defining, measuring, and paying for quality. Experts discussed the role of outcomes-based oncology quality measures in policy decision-making, including how the patient experience is considered and applied in clinical decision-making. Key topics of discussion included: implications for rising drug costs, the impact and sustainability of the Oncology Care Model (OCM), opportunities for expanding the role of patient-reported outcomes (PROs), and action steps for improving quality measurement.

#### Rising Drug Costs: Challenges in Controlling Overall Cost of Care

**Speaker:** Kerin Adelson, MD, Yale Cancer Center/Smilow Cancer Hospital

- Drugs are estimated to account for 20% of the total cost of cancer care among Medicare beneficiaries, which is expected to reach \$173 billion by 2020. This estimate may not accurately reflect Part B and Part D drug costs, which may be much higher. The OCM creates an opportunity to better understand Part B and Part D drug costs in cancer care.
- Yale implemented infrastructure to support physicians, funded through the OCM care coordination payments. These include:
  - Understanding how providers are performing on goals-of-care discussions, patterns of practice, and communication
  - Developing tools to provide feedback to physicians with the intent of having them take ownership of their data without increasing burden
  - Using claims data to benchmark physicians against overall OCM performance by creating individual provider stories
  - Developing dashboards to understand prescribing practices and drill down to patient-specific data
- Yale used OCM claims to assess total cost of care for Medicare patients on systemic therapy and found an increase in the total cost per episode, but the increase was still lower than the Center for Medicare & Medicaid Innovation (CMMI) cost benchmark. Other key results included:
  - Decreased incidence of emergency department care, inpatient care, and post-acute care
  - Increased mean drug costs
    - Pharmaceuticals accounted for at least 60% of total cost for practices that achieved savings, indicating that cost containment is dependent on the cost of drugs.

#### OCM: A Community Oncology Perspective

**Speaker:** Diana Verrilli, MS, McKesson Specialty Health

- McKesson Specialty Health US Oncology Network is the largest participant in the OCM, with \$89 million in savings achieved over two years and an average quality score of 9 out of 10.
- US Oncology's success in the OCM involves:

- Following targeted efforts around drug utilization
- Providing more data to physicians
- Increasing patient access, touch points, and education
- Partnering with NCCN to develop value pathways
- US Oncology’s lessons learned include:
  - Reporting is very hard, and it took a minimum of two years to transform practices to OCM requirements.
  - Electronic health records (EHRs) play a key role in collecting data.
  - Appropriate staff are needed to complete the tasks that lead to success in the OCM.
  - Physicians were anxious about how they would perform in the OCM.
  - Major successes included practice transformation, enhanced patient and physician engagement, and identifying paths for practices to move to two-sided risk, retain one-sided risk, or exit the program depending on performance and priorities.
- Adoption of two-sided risk does not change practices’ focus on quality measures. Key OCM two-sided risk considerations include upside benefit, quality, two-sided risk confidence, risk tolerance, and exemption from submitting data to the Merit-based Incentive Payment System (MIPS).

### Panel Discussion 1: Application and Measurement of Quality in Cancer Care Delivery Systems: Challenges and Lessons Learned

**Moderator:** Clifford Goodman, PhD, The Lewin Group

**Panelists:** Kerin Adelson, MD, Yale Cancer Center/Smilow Cancer Hospital; Alan Balch, PhD, National Patient Advocate Foundation; Alexandra Chong, PhD, CMMI; Nancy L. Keating, MD, MPH, Dana-Farber/Brigham and Women’s Cancer Center and Massachusetts General Hospital Cancer Center; Diana Verrilli, MS, McKesson Specialty Health; Jacqueline Waldrop, MS, Pfizer; Tracy Wong, MBA, Seattle Cancer Care Alliance

- Panelists discussed distinguishing characteristics of their quality measure programs:
  - Yale Cancer Center partnered with Flatiron Health, a health care solutions company focusing on cancer technology platforms and research, and Tuple Health, a physician-led design and technology company developing new models of care for clinical improvement, to understand practices’ characteristics and measure what matters, not just what is measurable.
  - The National Patient Advocate Foundation wants to reduce quality measure burden for practices and ensure measure sets reflect issues that matter to patients (e.g., shared decision-making, care planning, work disruption, caregiver burden).
  - Dana-Farber/Brigham and Women’s Cancer Center works to understand the goal and purpose of any type of quality measurement.
  - Pfizer is examining which patient-reported measures are most important to patients through grant projects (ex: MyPROfile at Yale enables patients to decide what to report).
  - McKesson Specialty Health focuses on Qualified Clinical Data Registries (QCDRs) to define and measure what is most valuable to physicians.
  - The Seattle Cancer Care Alliance works to avoid fragmented measure sets by creating connections between what matters to each stakeholder group.
- Panelists discussed the impact of the OCM to date:
  - Impacted practice culture (i.e., physician engagement, care team model, focus on patients) and rejuvenated staff, bringing new life to routine workflow.
  - Yielded positive patient feedback, with patients feeling like their voice is being heard.

- Resulted in the creation of infrastructure built to care for patients in a holistic way, including hiring of staff funded by OCM payments.
- Resulted in growing pains, but practices are now in their “groove” and implementing models to transform practice. Organizations are actively thinking about the sustainability of the model.
- Created a need to identify what matters most to patients and translate those priorities into patient-reported outcome measures (PROMs).
  - Patients want to feel respected and listened to, and receive care that is personalized.
  - The National Patient Advocate Foundation is researching and surveying patients on what is important to them and identified top issues including financial toxicity, care burden, work disruption, and transportation burden.
- Triggered conversations with local commercial payers about the introduction of similar programs.
- Put the patient voice at the center of care delivery, and drove the development of products and concepts to remove burden from payers and providers and break down silos.
- Led to a wide impact on practices, payers, and those not participating in the OCM.
  - CMMI is hearing positive responses from practices that the OCM is an opportunity to provide the type of care they want.
  - Pain and depression screening requirements are forcing providers to address issues with comorbidities and risk stratification.
  - The OCM has supported the expansion of value-based care in other specialty models and bundled care.
- Panelists discussed the role that digitization has played in quality programs:
  - Practices have been able to access more internal data and have increased their ability to monitor and analyze data.
  - Systems are experiencing “analysis paralysis” from trying to distill so much information into something meaningful that will move the dial on quality. The current state of digitization is going to require institutions to have data teams that pull together and interpret disparate information.
  - Missing data highlights improvement opportunities for systems.
  - The OCM has provided the opportunity to understand a patient’s care journey from end to end.
  - Data lags are a major challenge and can cause duplicative measurement, as systems cannot act with outdated data. Receiving data on a monthly or quarterly basis would decrease administrative cost and burden.
  - There is still a lack of data across payers and care settings.
  - The most important thing for patients is the ability to choose key measures for their care plan. Ideally, this would include a patient portal to allow them to see performance on measures most important to them.
- Panelists discussed the challenges of measuring outcomes:
  - Risk adjustment is a key challenge; for example, you cannot measure lung cancer survival without adjusting for patient stage and tumor markers.
  - Nonclinical factors such as socioeconomic status can affect outcomes.

- Most OCM measures are process measures that require burdensome manual collection; Having patients more involved in the measure development process could lead to more desired measures.
- The effects of immunotherapy long-term and the impact of confounding clinical factors increase the complexity of measuring quality for this population.
  - Novel drugs have not been shown to keep patients out of the hospital and if anything, they may be increasing utilization due to increasing toxicities.
- Panelists discussed priority measure development areas:
  - Measures that address social determinants of health for day-to-day living
  - Measure sets that allow practices to decide for themselves where they want to be and put in place metrics they want to measure instead of just requiring them to check a box
  - PROs/patient-reported experiences, but avoid abandoning care process measures
- Panelists provided suggestions to the Centers for Medicare & Medicaid Services (CMS) for a future version of the OCM:
  - Emphasized the need to focus on biosimilars.
  - Communicated the importance of continuing the OCM, as abandoning the program would be detrimental and lead to staff layoffs. Many sites that didn't join in the first round may want to join in the future.
  - Encouraged measurement of financial burden for patients.
  - Emphasized creating a systematic approach and providing more incentives for shared decision-making and care planning so that it isn't a check-the-box effort.
  - Encouraged the development of mandatory models to allow for randomization of practices to better evaluate the impact of OCM participation.

## The Role of Standardized Performance Measures in Ensuring Quality in Cancer Care

**Speaker:** Shantanu Agrawal, MD, MPhil, National Quality Forum (NQF)

- The NQF Cancer Portfolio makes up 5% of NQF's total endorsed measures.
- The majority of NQF-endorsed cancer measures are process or structure: 26 process/structure measures, two outcome measures.
- The NQF Incubator™ is currently managing projects on diagnostic accuracy and evidence-based treatment, survival rates, and patient-reported measures.
- The main challenges in measurement are misalignment, difficulty of collection, and context for use.
- The Core Quality Measures Collaborative (CQMC) Oncology set will be updated soon, and NQF will be releasing an issue brief on serious illness care initiatives in 2020.

## Panel Discussion 2: The Future of Defining, Standardizing, and Reporting Quality in Cancer Care

**Moderator:** Clifford Goodman, PhD, The Lewin Group

**Panelists:** Reena Duseja, MD, MS, CMS; Bryan Loy, MD, MBA, Humana; Jim Martineau, MBA, Flatiron; Kashyap Patel, MD, Carolina Blood and Cancer Care; Lawrence N. Shulman, MD, Abramson Cancer Center at the University of Pennsylvania; Gaurav Singal, MD, Foundation Medicine; Ronald S. Walters, MD, MBA, MHA, MS, The University of Texas MD Anderson Cancer Center

- Panelists discussed the role of PROs in quality to date:
  - PROs are in their very early days, and there are varying levels of adoption.

- Survival data is not currently linked to PROs, so little is known about the quality of life following treatment.
- The University of Pennsylvania electronically collects PROs that flow into the EHR for providers to see at the time of the appointment.
- It is more of a process change than a cost issue to measure PRO data.
- The ultimate goal is to link PROs to the Surveillance, Epidemiology, and End Results Program (SEER) and other large oncology databases.
- PROs are sometimes a check box measure, but if you have the right processing in place, you may have some predictive elements for understanding potential effects of treatment.
- CMS recognized PROs as a key gap area, but there has been more and more interest in collecting other outcome measures.
- MIPS provides an opportunity to collect PRO data and learn from it.
- Standardization needs to improve, and the core elements to be collected across conditions must be determined.
- Development of PROs and practice performance is important for underserved areas, and CMMI should look into assessing social, ethnic, and relational characteristics.
- Panelists discussed CMS' proposal to create MIPS "value pathways" (MVPs) beginning in 2021:
  - MIPS is creating confusion due to the many reporting requirements.
  - CMS hopes to partner with societies and registries to identify a cohesive set of measures.
  - Panelists recommended the following:
    - Measure all-cause readmission because it is an opportunity for improvement and root cause around failure of coordination of care.
    - Document whether the patient understands their disease and the likely trajectory.
    - "Mix and match" specialized measures that generate discussion and cross-cutting measures that include a core set of outcomes that apply to everyone.
    - Make sure what is asked to be measured can be measured in a data dump format on an ongoing basis.
    - Measure whether the provider followed NCCN guidelines.
    - An important measure is whether the patient was kept out of the emergency department.
- Panelists discussed priorities for measurement in future versions of the OCM:
  - Reporting and administrative burden needs to be reduced.
    - Measures need to be continually reevaluated to ensure that compliance is associated with better outcomes.
  - Practices have been challenged by new drugs and accompanying costs.
  - Structural measures can be used as a starting point when process and outcome measures are not feasible. Two key structural measures are:
    - Whether the practice uses at least one PRO
    - Whether the practice uses at least one shared decision-making tool
- Panelists discussed domains on which there should be alignment:
  - Care team understanding of how well the patient will adhere to the care plan
  - Measures to assess whether data informs decisions
  - Getting the right care for goals and doing the right thing to optimize cost



- Look into and incorporate demographics, comorbidities, financial status, socioeconomic status, etc.
- Increase agility in developing relevant quality metrics
  - A validated platform of data measurement to create more rapid measures could enable more efficient development of measures to keep up with emerging therapies.
    - The counterpoint is that this assumes there is a standardized platform that everyone agrees on and uses.
    - There is an effort going on called mCODE (Minimal Common Data Elements) that focuses on knowing what the critical data elements are, agreeing upon them, and getting them in a structured format in all EHRs.
- Assess dissemination and adoption of new therapies
- Make sure what is measured is meaningful and leads to desired outcomes
- Measure areas of functional status, goals of care, care coordination, and “how life is going” (e.g., finances, food security)