



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 1858

Corresponding Measures:

De.2. Measure Title: Trastuzumab administered to patients with AJCC stage I (T1c) – III human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy

Co.1.1. Measure Steward: American Society of Clinical Oncology

De.3. Brief Description of Measure: Percentage of female patients aged 18 and over with HER2/neu positive invasive breast cancer who are administered trastuzumab

1b.1. Developer Rationale: Approximately 15% of patients with breast cancer have tumors that overexpress the human epidermal growth hormone receptor protein (HER2). The American Society of Clinical Oncology (ASCO) envisions that use of this measure will improve concordance with recommendations for Trastuzumab administration for patients with AJCC stage I(T1c) – III, HER2/neu positive breast cancer. We recognize the importance of ensuring that the appropriate patient population receives guideline concordant treatment as studies have shown that the administration of Trastuzumab significantly improves overall survival in patients with high-risk HER2 positive breast cancer.

S.4. Numerator Statement: Patients for whom trastuzumab is administered within 12 months of diagnosis

S.6. Denominator Statement: Female patients aged 18 and over with AJCC stage I (T1c) – III, HER2/neu positive breast cancer who receive chemotherapy

S.8. Denominator Exclusions: Denominator Exclusions:

o Patient transfer to practice after initiation of chemotherapy

Denominator Exceptions:

o Reason for not administering trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation therapy not complete)

De.1. Measure Type: Process

S.17. Data Source: Paper Medical Records, Registry Data

S.20. Level of Analysis: Clinician : Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: Oct 22, 2012 **Most Recent Endorsement Date:** Jul 31, 2020

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[1858_Evidence_MSF5.0_Data_11.23.2019.doc](#), [NQF_evidence_attachment_11.23.2019-637102982946754578.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Approximately 15% of patients with breast cancer have tumors that overexpress the human epidermal growth hormone receptor protein (HER2). The American Society of Clinical Oncology (ASCO) envisions that use of this measure will improve concordance with recommendations for Trastuzumab administration for patients with AJCC stage I(T1c) – III, HER2/neu positive breast cancer. We recognize the importance of ensuring that the appropriate patient population receives guideline concordant treatment as studies have shown that the administration of Trastuzumab significantly improves overall survival in patients with high-risk HER2 positive breast cancer.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

2019 Submission

Testing to identify statistically significant and meaningful differences in performance was conducted using 2017 MIPS performance from registry data provided from CMS. Practices were identified by unique number of TINs, and the 2017 data was from 73 unique TINs. Additional descriptive characteristics of the measured entities, such as size and location type, are unknown. Entities submitted data for inclusion in this data set according to the eligibility and reporting requirements for MIPS during the 2017 program year. We were unable to determine from our rolled-up data sample the number of clinicians who reported to MIPS as an individual or a group; therefore, this measure should be considered for endorsement at the group/practice level, with a potential group size as n of 1 or group of 1.

The NPI-level analysis of the 2017 MIPS data was conducted on 254 denominator-eligible patients. Additional descriptive characteristics of the measured patients are unknown. Eligible patients were included in this data set according to the reporting requirements for the 2017 MIPS program year.

An analysis of 73 unique TINs indicated that 25 percent of TINs have a denominator of two or less, and 50 percent of TINs have a denominator of five or less, and that the measure is heavily skewed with a large proportion of TINs performing perfectly (roughly 55 out of the 73 TINs). Additional details from the TIN-level analysis are provided below.

Number of unique entities: Frequency 73

Denominators

Min: 1; Q1: 2; Median: 5; Q3: 23; Max: 206; Total: 1815

Measure Distribution

Min: 0; Q1: 0.9853; Median: 1; Mean: 0.9307; Q3: 1; Max: 1; Cl.for.mean: (0.89, 0.98); Percent.outside.Cl: 90.41

An analysis of 250 unique NPIs indicated results similar to the TIN-level analysis, in that many NPIs have a small denominator, and the majority are already performing at 100 percent. Additional details from the NPI-level analysis are provided below.

Unique Number of NPIs: 250

Distribution of Measure Denominators and Measure Performance:

Denominator

Min: 0; Q1: 2; Median: 3; Mean: 6.072; Q3: 7; Max: 45

Measure:

Min: 0; Q1: 1; Median: 1; Mean: 0.9206; Q3: 1; Max: 1; CI.for.mean: (0.89, 0.95); Percent.outside.CI: 97.19

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

In a 2018 systematic review and meta-analysis of observational studies, Martin, et al. identified large variability in uptake of trastuzumab in HER2-positive early breast cancer patients (9.1-100%) and metastatic breast cancer patients (50.8-84.0%), with a pooled uptake of 71.3%. The authors noted the uptake of trastuzumab therapy varied widely between studies and across subgroups suggesting that there may be some inequalities in the use of trastuzumab.

Martin, A.P., et al., Trastuzumab uptake in HER2-positive breast cancer patients: a systematic review and meta-analysis of observational studies. Crit Rev Oncol Hematol, 2018. 130: p. 92-107.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

While this measure is included in the MIPS program, this program has not yet made disparities data available for ASCO to analyze and report.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

In a 2018 systematic review and meta-analysis of observational studies, Martin, et al. identified large variability in uptake of trastuzumab in HER2-positive early breast cancer patients (9.1-100%) and metastatic breast cancer patients (50.8-84.0%), with a pooled uptake of 71.3%. The authors noted the uptake of trastuzumab therapy varied widely between studies and across subgroups, suggesting inequalities exist in the use of trastuzumab. The authors suggested a cautious interpretation of findings due to study heterogeneity and potential confounding, and recommended additional studies using individual level data controlled for confounders in order to gain a better understanding about inequalities in trastuzumab use.

Martin, A.P., et al., Trastuzumab uptake in HER2-positive breast cancer patients: a systematic review and meta-analysis of observational studies. Crit Rev Oncol Hematol, 2018. 130: p. 92-107.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Cancer, Cancer : Breast

De.6. Non-Condition Specific(check all the areas that apply):

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_450_MIPSCQM.pdf

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

As 2017 MIPS data were used to complete updated testing, exclusions from the previous submission have been aligned with the MIPS specifications. We have also delineated between exceptions and exclusions in accordance with the MIPS measure specification.

Please note that one exclusion of “patient has metastatic disease at diagnosis” was removed from due to redundancy, as the denominator population is already limited to patients with stage I (T1c) - III cancer. We also intend to remove this from the MIPS specification as the measure update cycle allows.

We do not consider these modifications to be substantive to the measure.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients for whom trastuzumab is administered within 12 months of diagnosis

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses,

#1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy, Last Updated: Jul 31, 2020

code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Numerator:

Trastuzumab administered within 12 months of diagnosis

Numerator Options:

Performance Met: Trastuzumab administered within 12 months of diagnosis

OR

Denominator Exception: Reason for not administering Trastuzumab documented (e. g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation NOT complete)

OR

Performance Not Met: Trastuzumab not administered within 12 months of diagnosis

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

Female patients aged 18 and over with AJCC stage I (T1c) – III, HER2/neu positive breast cancer who receive chemotherapy

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Denominator Criteria (Eligible Cases):

Female Patients aged = 18 years on date of encounter

AND

Diagnosis of breast cancer

AND

Patient encounter during performance period

AND

Two or more encounters at the reporting site AND

Breast Adjuvant Chemotherapy administered:

AND

HER-2/neu positive:

AND

AJCC stage at breast cancer diagnosis = II or III: G9831

OR

AJCC stage at breast cancer diagnosis = I (IA or IB) and T-Stage at breast cancer diagnosis does NOT equal = T1, T1a, T1b

AND NOT

Denominator Exclusions:

Patient transfer to practice after initiation of chemotherapy

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Denominator Exclusions:

o Patient transfer to practice after initiation of chemotherapy

Denominator Exceptions:

o Reason for not administering trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation therapy not complete)

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Denominator Exclusions:

<p>Patient transfer to practice after initiation of chemotherapy</p>
<p>S.10. Stratification Information <i>(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)</i> N/A, no risk stratification</p> <p>S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment) No risk adjustment or risk stratification If other:</p>
<p>S.12. Type of score: Rate/proportion If other:</p> <p>S.13. Interpretation of Score <i>(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)</i> Better quality = Higher score</p> <p>S.14. Calculation Algorithm/Measure Logic <i>(Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)</i> This measure is a proportion with exclusions and exceptions; thus, the calculation algorithm is: Patients meeting the numerator + patients with valid exceptions/ (Patients in the denominator – Patients with valid exclusions) x 100</p>
<p>S.15. Sampling <i>(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</i> IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. Measure is not based on a sample.</p> <p>S.16. Survey/Patient-reported data <i>(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)</i> Specify calculation of response rates to be reported with performance measure results. N/A, measure is not based on a survey or instrument</p>
<p>S.17. Data Source <i>(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</i> If other, please describe in S.18. Paper Medical Records, Registry Data</p> <p>S.18. Data Source or Collection Instrument <i>(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)</i> IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration. N/A, measure is not instrument-based.</p> <p>S.19. Data Source or Collection Instrument <i>(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)</i> No data collection instrument provided</p> <p>S.20. Level of Analysis <i>(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)</i> Clinician : Group/Practice</p> <p>S.21. Care Setting <i>(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)</i> Outpatient Services If other:</p>

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2. Validity – See attached Measure Testing Submission Form

[1858_nqf_testing_attachment_7.31.2019.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

All the data elements needed for this measure are collected through electronic data or through the use of keyword searches. ASCO is in the process of assessing the feasibility of developing an electronic clinical quality measure.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Apart from the lack of availability of disparities data for analysis, we have not identified any areas of concern or made any modifications as a result of testing and operational use of this measure in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, or other feasibility issues unless otherwise noted.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

ASCO requests interested parties seek a licensing agreement prior to commercial use of this measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Merit-based Incentive Payment System (MIPS) reporting program, Center for Medicare and Medicaid Services

Prior to 2016, this measure was used for Eligible Providers (EPs) in the Physician Quality Reporting System (PQRS). As of 2017, MIPS replaced the PQRS program. MIPS is a national performance-based payment program that uses performance scores across several

categories to determine payment rates for EPs. MIPS takes a comprehensive approach to payment by basing consideration of quality on a set of evidence-based measures that were primarily developed by clinicians, thus encouraging improvement in clinical practice and supporting advances in technology that allow for easy exchange of information. Data on geographic area and number and percentage of accountable entities and patients, including level of measurement and setting, are unavailable for analysis.

QOPI® Qualified Clinical Data Registry

This measure has been reported to CMS by the registry as a Qualified Clinical Data Registry. The Quality Oncology Practice Initiative (QOPI®) was deemed as a registry for oncology measures group reporting and as a QCDR to report to PQRS in 2015 and 2016 and to report to MIPS in 2017, 2018 and 2019. Eligible professionals will be considered to have satisfactorily participated in MIPS if they submit quality measures data or results to CMS via a qualified clinical data registry. In 2017 and 2018, a total of 19 practices representing approximately 50,000 patient charts submitted to MIPS through QOPI. CMS has implemented a phased approach to public reporting performance information on the Physician Compare website.

Core Quality Measure Collaborative's (CQMC) Medical Oncology Core Measure Set

This measure has also been included in the Core Quality Measure Collaborative's (CQMC) Medical Oncology Core Measure Set. The CQMC is a broad-based coalition of health care leaders convened by America's Health Insurance Plans (AHIP) starting in 2015. The purpose of this program is to reduce variability in measure selection, specifications and implementation. The CQMC defines a core measure set as a parsimonious group of scientifically sound measures that efficiently promote a patient-centered assessment of quality and should be prioritized for adoption in value-based purchasing and APMs. The CQMC has developed and released core sets of quality measures that could be implemented across both commercial and government payers. The measures have been implemented nationally by private health plans using a phased-in approach. Contracts between physicians and private payers are individually negotiated and therefore come up for renewal at different points in time depending on the duration of the contract. It is anticipated that private payers will implement these core sets of measures as and when contracts come up for renewal or if existing contracts allow modification of the performance measure set. CMS is also working to align measures across public program.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

This measure is currently used in an accountability application and public reporting is forthcoming. According to the CY 2019 Quality Payment Program final rule, Physician Compare has continued to pursue a phased approach to public reporting under MACRA. CMS intends to make all measures under MIPS quality performance category available for public reporting on Physician Compare. These measures include those reported via all available submission methods for MIPS-eligible clinicians and groups. Because this measure has been in use for at least one year and meets the minimum sample size requirement for reliability, this measure meets criteria for public reporting but has not yet been included in Physician Compare.

As described above, CMS is also planning to publicly report QCDR data. Additionally, although the measure is currently in use, we will continue to seek opportunities to advocate for expanded use of this measure in government or other programs.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

Despite not yet being included in Physician Compare, this measure meets criteria for public reporting because it has been in use for at least one year and meets the minimum sample size requirement for reliability; this measure meets criteria for public reporting.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

ASCO's measure development process is rigorous, evidence-based, and utilizes the clinical expertise of multiple standing multi-disciplinary Technical Expert Panels (TEPs) dedicated to development and maintenance of measures across the cancer continuum. During measure maintenance, TEP members are provided with full measure specifications, applicable evidence, historical measure performance data, and any external feedback or requests for clarification or updates that have been received for the measure.

Staff on ASCO's measure development team are available to receive comments and questions from measure implementers and clinicians reporting the measures. As comments and questions are received, they are shared with appropriate staff for follow up. If comments or questions require expert input, these are shared with ASCO's TEPs to determine if measure modifications may be warranted. Additionally, for ASCO measures included in federal reporting programs, there is a system that has been established to elicit timely feedback and responses from ASCO staff in consultation with TEP members, as appropriate.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

See description in 4a2.1.1 above.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

In addition to the feedback obtained from a multi-disciplinary technical expert panel during the measure development and maintenance process, ASCO obtains feedback and receives measure inquiries from implementers and reporters via email. No specific feedback has been received by ASCO on this measure.

4a2.2.2. Summarize the feedback obtained from those being measured.

No specific feedback has been received by ASCO on this measure. However, we will continue to solicit feedback from MIPS users, and from the general public as we perform maintenance on this measure.

4a2.2.3. Summarize the feedback obtained from other users

No additional feedback has been received by ASCO on this measure. However, we will continue to solicit feedback as we perform maintenance on this measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

As stated in 4a2.2, ASCO did not receive specific feedback on this measure; therefore, ASCO's TEP did not consider external feedback from those being measured during revision of measure specifications or implementation.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Analysis of MIPS data from 2017 at the TIN level indicated the measure is heavily skewed with a large proportion of TINs performing perfectly (roughly 55 out of the 73 TINs). The majority of TINs perform at 100%, although there are multiple TINs whose performance is below 25%. An analysis of 250 unique NPIs indicated results similar to the TIN-level analysis, in that many NPIs have a small denominator, and the majority are already performing at 100 percent.

Additionally, the 2017 QPP Experience Report Appendix indicates performance on this measure is at 97.51 percent, and 2019 MIPS benchmarking data for QI 450 indicates this measure is topped out. Consistent with these findings, ASCO's interpretation is that NQF 1858 is topped out.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

At this time we are not aware of any unintended consequences related to this measure. We take unintended consequences very seriously and therefore continuously monitor to identify actions that can be taken to mitigate them.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

We have not observed any unexpected benefits associated with implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

1855 : Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines

1857 : HER2 negative or undocumented breast cancer patients spared treatment with HER2-targeted therapies

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

N/A - The measure specifications are harmonized.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

An environmental scan did not identify competing measures. ASCO believes that NQF 1857 is a complementary measure assessing the inverse of the quality action captured in NQF 1858. Furthermore, because NQF 1857 is endorsed with reserve status and is no longer in use, harmonization is therefore not required. We believe NQF 1855 is a complementary measure assessing HER2 testing, which is an integral component to NQF 1858, and harmonization is not required.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Society of Clinical Oncology

Co.2 Point of Contact: Angela, Kennedy, Angela.kennedy@asco.org, 571-483-1656-

Co.3 Measure Developer if different from Measure Steward: American Society of Clinical Oncology

Co.4 Point of Contact: Angela, Kennedy, Angela.kennedy@asco.org, 571-483-1656-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

ASCO's breast and gynecologic-oncology Technical Expert Panel (TEP) is a standing multi-disciplinary panel responsible for maintenance and de novo development of ASCO breast and gyn-onc measures. TEP members provide clinical expertise and guidance on measure concepts, level and quality of evidence, and measure specifications. The current TEP roster is as follows:

- Katherine Enright, MD, MPH

Co-Chair - Breast

Cancer Care Ontario – Trillium Health Partners

- Alexi Wright, MD, MPH

Co-Chair – Gyn-onc

Dana-Farber Cancer Institute

- Kerin B. Adelson, MD

Yale School of Medicine Smilow Cancer Center

- Deborah Armstrong, MD

Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins

- Lisa Barbera, MD

Tom Baker Cancer Centre

- Victoria Blinder, MD

Memorial Sloan Kettering Cancer Center 1275 York Ave

- Gary Cohen, MD, FASCO

(Retired) Johns Hopkins School of Medicine

- Neelima Denduluri, MD

US Oncology – Virginia Cancer Specialists

- Nefertiti C. duPont, MD, MPH

North Houston Gynecologic Oncology Surgeons

- Amanda Nickels Fader, MD

Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins

#1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy, Last Updated: Jul 31, 2020

•Carol Hahn, MD, FASTRO
Duke Cancer Center Wake County

•Alexander Melamed, MD, MPH
Columbia University Medical Center

•Monica Morrow, MD, MPH, FASCO, FACS
Memorial Sloan Kettering Cancer Center

•Preeti Sudheendra, MD
MD Anderson Cancer Center at Cooper University Hospital

•William Tew, MD
Memorial Sloan Kettering Cancer Center

•Ann Von Gehr, MD, FACP
Washington Permanente Medical Group

•Jason Wright, MD, FACOG
Columbia University

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 07, 2019

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 07, 2020

Ad.6 Copyright statement: The Measure is not clinical guidelines, does not establish a standard of medical care, and has not been tested for all potential applications.

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Ad.8 Additional Information/Comments: