



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 #: [2372](#)

Corresponding Measures:

De.2. Measure Title: [Breast Cancer Screening](#)

Co.1.1. Measure Steward: [National Committee for Quality Assurance](#)

De.3. Brief Description of Measure: [Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer](#)

1b.1. Developer Rationale: [This measure assesses screening for breast cancer using mammography, which can prevent or detect early breast cancer, as well as reduce deaths from breast cancer. Early detection of breast cancer by mammography may also allow for a greater range of treatment options, including less-aggressive surgery and less-invasive therapy.](#)

S.4. Numerator Statement: [Women who received a mammogram to screen for breast cancer.](#)

S.6. Denominator Statement: [Women 50-74 years of age.](#)

S.8. Denominator Exclusions: [This measure excludes women with a history of bilateral mastectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan or living long-term in an institution any time during the measurement year.](#)

De.1. Measure Type: [Process](#)

S.17. Data Source: [Claims, Electronic Health Data](#)

S.20. Level of Analysis: [Health Plan, Integrated Delivery System](#)

IF Endorsement Maintenance – Original Endorsement Date: [Sep 18, 2014](#) Most Recent Endorsement Date: [Oct 25, 2018](#)

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

[2. Evidence_Form_USPSTF_BCS.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.

This measure assesses screening for breast cancer using mammography, which can prevent or detect early breast cancer, as well as reduce deaths from breast cancer. Early detection of breast cancer by mammography may also allow for a greater range of treatment options, including less-aggressive surgery and less-invasive therapy.

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.

The following health-plan level data are collected through HEDIS and reflect the most recent years of measurement for this measure. Performance data are summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at 10th, 25th, 50th, 75th, and 90th percentile. Data are stratified by year and product line (i.e. commercial, Medicaid, Medicare).

Commercial HMO/PPO Rate

YEAR	N	MEAN	STDEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2015	410	71.9%	5.9%	52.0%	64.8%	68.1%	71.1%	75.8%	80.5%	89.6%
2016	426	71.4%	6.5%	37.2%	64.5%	67.7%	71.0%	75.4%	80.2%	88.2%
2017	420	71.4%	7.0%	13.2%	64.0%	68.0%	71.2%	75.7%	79.8%	88.0%

Medicaid HMO Rate

YEAR	N	MEAN	STDEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2015	170	58.77%	09.75%	36.70%	45.99%	51.59%	58.37%	66.02%	71.32%	87.88%
2016	201	58.51%	10.09%	17.78%	47.38%	52.28%	58.10%	65.06%	71.44%	88.51%
2017	257	58.87%	09.24%	30.56%	48.00%	52.71%	59.02%	65.51%	70.29%	87.92%

Medicare HMO/PPO Rate

YEAR	N	MEAN	STDEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2015	425	71.0%	11.3%	09.8%	60.5%	66.8%	71.7%	78.4%	82.9%	92.1%
2016	405	72.4%	09.8%	14.3%	62.0%	67.4%	72.7%	79.2%	83.3%	91.9%
2017	431	72.2%	09.6%	18.4%	61.4%	67.0%	73.0%	78.8%	82.9%	91.1%

In 2016, HEDIS measures covered 114.2 million commercial health plan beneficiaries, 47 million Medicaid beneficiaries and 17.6 million Medicare beneficiaries. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

Breast Cancer Screening – commercial

YEAR	N Plans	Median Denominator Size per plan
2015	410	7,740
2016	426	7,510
2017	420	7,552

Breast Cancer Screening – Medicaid

YEAR	N Plans	Median Denominator Size per plan
2015	172	1,642
2016	202	1,419
2017	258	2,439

Breast Cancer Screening – Medicare

YEAR | N Plans | Median Denominator Size per plan

2015 | 425 | 2,173

2016 | 405 | 2,297

2017 | 431 | 1,890

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.

N/A

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.

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, health plans can stratify by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, the NCQA Multicultural Health Care Distinction Program outlines standards for collecting, storing and using race/ethnicity and language data to assess health care disparities. Starting in 2019, Medicare Advantage plans will report this measure stratified by low-income subsidy/dual eligibility and disability status, which are proxies for low socioeconomic status.

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

Studies have identified disparities in breast cancer screening based on race, ethnicity, education and income. One study found that mammography use in 2006 was 65 percent among white women and 59 percent among black women (Njai et al 2011). Additionally, African American women are more likely than white women to have longer intervals between screening mammograms, which may lead to an increase in later-stage cancer diagnoses (CDC 2012). Between 2010 and 2014, breast cancer mortality for African American women was 41 percent higher than white women (Richardson et al 2016); one potential contributing factor to this health disparity is access to mammography screening services (Rust et al 2015). National survey data also show that women who have attained lower degrees of education, lack health insurance coverage or have lower socioeconomic status are less likely to have recently had a mammogram (National Center for Health Statistics 2015).

National Center for Health Statistics. 2015. “Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities”. <http://www.cdc.gov/nchs/data/abus/abus15.pdf#070> (Accessed Mar 13, 2018).

Njai, R., Siegel, P. Z., Miller, J. W., & Liao, Y. 2011. “Misclassification of Survey Responses and Black-White Disparity in Mammography Use, Behavioral Risk Factor Surveillance System, 1995-2006.” Preventing Chronic Disease 8(3), A59.

Richardson, L.C., Henley, S.J., Miller, J.W., Massetti, G., and Thomas, C.C. 2016. “Patterns and Trends in Age-Specific Black-White Differences in Breast Cancer Incidence and Mortality – United States, 1999–2014.” Morbidity and Mortality Weekly Report (MMWR) 65(40); 1093-1098. (November 30, 2016) <http://www.cdc.gov/mmwr/volumes/65/wr/mm6540a1.htm>.

Rust, G., Zhang, S., Malhotra, K., Reese, L., McRoy, L., Baltrus, P., Caplan, L. and Levine, R. 2015. “Paths to Health Equity – Local Area Variation in Progress Toward Eliminating Breast Cancer Mortality Disparities, 1990–2009.” Cancer 121(16): 2765-2774. (December 1, 2016) doi: 10.1002/cncr.29405.

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):

Primary Prevention, Screening

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

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.)

N/A

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)

Attachment Attachment: 2372_Breast_Cancer_Screening_Value_Sets-636594894640541618.xlsx

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.

Since the last NQF review, digital breast tomosynthesis was added as an acceptable breast cancer screening method in order to account for the use of this method by women with clinical indications. This change was reviewed by stakeholder groups, vetted through a public comment period, and approved by our committees.

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).

Women who received a mammogram to screen for breast cancer.

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, 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).

One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Notes:

(1) This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance. MRIs, ultrasounds or biopsies do not count toward the numerator; although they may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not themselves count toward the numerator.

(2) The numerator time frame is 27 months. NCQA allows for a 3-month leeway, a method used for other HEDIS measures (as determined on a per-measure basis), in recognition of the logistics of referrals and scheduling and to avoid potential overuse of screening. This time frame was recommended by our expert advisory panels and approved by our Committee on Performance Measurement, which oversees measures used in the HEDIS Health Plan Measures Set.

See attached code value sets.

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

Women 50-74 years of age.

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).

Women 52-74 years as of the end of the measurement year (December 31).

Note: this denominator statement captures women age 50-74 years; it is structured to account for the look-back period for mammograms.

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

This measure excludes women with a history of bilateral mastectomy. The measure also excludes patients who use hospice services or are enrolled in an institutional special needs plan or living long-term in an institution any time during the measurement year.

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.)*

Exclude patients with bilateral mastectomy any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria for bilateral mastectomy:

- 1) Bilateral mastectomy (Bilateral Mastectomy Value Set)
- 2) Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set)
- 3) Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart
- 4) History of bilateral mastectomy (History of Bilateral Mastectomy Value Set)
- 5) Any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service. Left mastectomy includes any of the following: unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) same claim; or absence of the left breast (Absence of Left Breast Value Set); or left unilateral mastectomy (Unilateral Mastectomy Left Value Set). Right Mastectomy includes any of the following: unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) same claim; or absence of the right breast (Absence of Right Breast Value Set); or right unilateral mastectomy (Unilateral Mastectomy Right Value Set).

Exclude patients who use hospice services any time during the measurement year (Hospice Value Set).

Exclude patients 65 and older who are enrolled in an institutional SNP or living long-term in an institution at any time during the measurement year.

S.10. Stratification Information (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.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (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)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (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.)

Step 1. Determine the eligible population: identify women 52-74 years of age by the end of the measurement year.

Step 2. Search for an exclusion: history of bilateral mastectomy; or use of hospice services during the measurement year; or patients 65 and older who are enrolled in an institutional SNP or living long-term in an institution any time during measurement year.

Exclude these patients from the eligible population.

Step 3. Determine numerator: the number of patients who received one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Step 4. Calculate the rate.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Electronic Health Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan, Integrated Delivery System

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

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

Testing_Form_BCS_Revised_5.8.18.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), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

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**.

ALL data elements are in defined fields in electronic claims

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).

N/A

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.

This measure is specified for administrative data, which has been found to be highly feasible. Further, NCQA conducts an independent audit of all HEDIS collection and reporting processes in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans. The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Through our Policy Clarification Support System, NCQA responds immediately to technical questions regarding measures in order to promote consistent implementation of the measure.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation, information from NCQA auditing and Policy Clarification Support System (as well as through stakeholder advisory panels) informs evaluation of the scientific soundness and feasibility of the measure.

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).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the 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

CALIFORNIA VALUE BASED PAY FOR PERFORMANCE PROGRAM: This measure is used in the California P4P program, which is the largest non-governmental physician incentive program in the United States. Founded in 2001, it is managed by the Integrated Healthcare Association (IHA) on behalf of ten health plans representing 9 million insured persons. IHA reports results on approximately 35,000 physicians in 200 physician organizations.

CMS MEDICARE ADVANTAGE STAR RATING PROGRAM: This measure is included in the composite Medicare Advantage Star Rating. CMS calculates a Star Rating (1-5) for all Medicare Advantage health plans based on 53 performance measures. Medicare beneficiaries can view the star rating and individual measure scores on the CMS Plan Compare website. The Star Rating is also used to calculate bonus payments to health plans with excellent performance. The Medicare Advantage Plan Rating program covers 11.5 million Medicare beneficiaries in 455 health plans across all 50 states.

CMS MEDICAID ADULT CORE SET: There are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers of Medicare & Medicaid (CMS) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

CMS QUALIFIED HEALTH PLAN (QHP) QUALITY RATING SYSTEM (QRS): This measure is used in the Qualified Health Plan (QHP) Quality Rating System, which provides comparable information to consumers about the quality of health care services and QHP enrollee experience offered in the Marketplaces.

CMS QUALITY PAYMENT PROGRAM: This measure is used in the Quality Payment Program (QPP) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

NCQA STATE OF HEALTH CARE QUALITY REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2012, the report included measures on 11.5 Medicare Advantage beneficiaries in 455 Medicare Advantage health plans, 99.4 million members in 404 commercial health plans, and 14.3 million Medicaid beneficiaries in 136 plans across 50 states.

NCQA HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings, which are reported in Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2012, a total of 455 Medicare Advantage health plans, 404 commercial health plans, and 136 Medicaid health plans across 50 states were included in the rankings.

NCQA HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. In 2012, a total of 170 Medicare Advantage health plans were accredited using this measure among others covering 7.1 million Medicare beneficiaries and 336 commercial health plans covering 87 million lives. Health plans are scored based on performance compared to benchmarks.

NCQA QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

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?)

N/A

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.)

N/A

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.

During development, NCQA receives input from those reporting and using measures through several multistakeholder advisory panels and a broad public comment posting. For this particular measure, the clinical advisory panel included several representatives from health plans and users such as federal policymakers and consumers. We also sought input from our standing Technical Measurement Advisory Panel, which includes representatives from health plans and other users and advises NCQA on feasibility and other potential implementation issues. During implementation, health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

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.

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c.1.

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.

NCQA measures are evaluated regularly using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

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

During development and reevaluation, those reporting and using measures reported the measure continues to be relevant and important for quality improvement and accountability. Questions received through the Policy Clarification Support system have generally sought clarification about the mammography screening methods that satisfy the measure numerator. During a recent public comment session, a majority of comments from measured entities supported updates to the measure to align with the latest clinical recommendations.

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

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the Medicare Advantage Star Rating program and the Medicaid Adult Core Set.

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.

During the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure to include digital breast tomosynthesis as a new screening method.

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.

From 2011 to 2017, average performance rates increased by about six percentage points for Medicare and Medicaid plans and were steady for commercial plans. Over the past three years, average performance rates slightly increased for Medicare plans and were stable for Commercial and Medicaid plans. In 2017, average performance was about 71% for Commercial and Medicare plans, and 59% for Medicaid plans.

There continues to be variation between the 10th and 90th percentile, suggesting room for improvement. In 2017, commercial plans in the 10th percentile had a rate of 64% compared to 80% for plans in the 90th percentile; Medicare plans in the 10th percentile had a rate of 61% compared to 83% for plans in the 90th percentile; and Medicaid plans in the 10th percentile had a rate of 48% compared to 70% for plans in the 90th percentile.

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.

One potential unintended consequence of the Breast Cancer Screening measure is too-frequent screening. The U.S. Preventive Services Task Force recommends biennial screening in women age 50-74. Feedback from our advisory panel indicated that, in an effort to meet the two-year requirement, women often are encouraged to seek screening earlier than the two-year mark. In order to address potential over-screening, NCQA adjusted the numerator time frame to 27 months, providing a three-month leeway to account for the logistics of scheduling and receiving a mammogram.

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

Benefits from implementation of the measure were as expected.

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)

0508 : Diagnostic Imaging: Inappropriate Use of “Probably Benign” Assessment Category in Screening Mammograms

0509 : Diagnostic Imaging: Reminder System for Screening Mammograms

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

N/A

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.

Both related measures have a different focus than our health plan screening measure. NQF #0509 Reminder System for Mammograms is intended to encourage implementation of reminder systems for future mammograms. NQF #0508 Inappropriate Use of “Probably Benign” Assessment Category focuses on accurate documentation of mammogram results. Both measures are also specified at the clinician level rather than the health plan level.

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.)

N/A

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.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

Co.2 Point of Contact: Bob, Rehm, rehm@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: [National Committee for Quality Assurance](#)

Co.4 Point of Contact: Bob, Rehm, rehm@ncqa.org, 202-955-1728-

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.

The NCQA Breast Cancer Screening Measurement Advisory Panels advised NCQA during measure development. They evaluated the way staff specified the measure, reviewed field test results, and assessed NCQA's overall desirable attributes of Relevance, Scientific Soundness, and Feasibility. The advisory panel consisted of a balanced group of experts. In addition to this advisory panel, we vetted the measure with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders.

2014 BREAST CANCER SCREENING MEASUREMENT ADVISORY PANEL MEMBERS

Kathy Coltin, Harvard Pilgrim Health Care

Laura Esserman, University of California, San Francisco

Lisa Latts, formally at WellPoint, Inc.

Nancy Lee, U.S. Department of Health & Human Services

Dorothy Mann, UW School of Medicine and School of Public Health and Community Medicine

Melissa McNeil, University of Pittsburgh

Ellen Stovall, National Coalition for Cancer Survivorship

Richard Wender, Thomas Jefferson University

2017 BREAST CANCER SCREENING MEASUREMENT ADVISORY PANEL MEMBERS

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Harmon Jordan, Westat
Virginia Raney, Center for Medicaid and CHIP Services
Lynne Rothney-Kozlak, Rothney-Kozlak Consulting, LLC
Laurie Spoll, Aetna

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 1995

Ad.3 Month and Year of most recent revision: 04, 2018

Ad.4 What is your frequency for review/update of this measure? Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure? 12, 2019

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