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Memo

November 18, 2020

To: Consensus Standards Approval Committee (CSAC)

From: Prevention and Population Health Project Team

Re: Prevention and Population Health 2020 Spring[a]

CSAC Action Required

The CSAC will review recommendations from the Prevention and Population Health project at its November 17-18, 2020 meeting and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. **Prevention and Population Health 2020 Spring Draft Report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.
2. **Comment Table**. Staff has identified themes within the comments received. This table lists three comments received during the post-meeting comment period and the NQF/Standing Committee responses.

Background

Population health is the collective well-being and functional ability of an identified group of people to experience their full capabilities. It has multiple environmental, behavioral, social, and biological determinants. Population health is generally understood as a systems-level concept that describes health outcomes of a group of individuals that are measured through a broad spectrum of public health, clinical care, socioeconomic, and physical environmental determinants that function interdependently and cumulatively. Population health not only focuses on disease and illness across multiple sectors, but also on health and well-being, prevention, and health promotion, as well as disparities in such outcomes and improvement activities within a group and/or between groups. Identifying valid and reliable measures of performance across these multiple sectors can be challenging. Data collection, health assessments at individual and aggregate levels, payment structures, quality of patient care, public health interventions, and other components present challenges in shaping widespread, standardized implementation of population health measures. Overcoming these challenges is critical to any strategy to understand and improve the health of populations.

The Prevention and Population Health Portfolio Standing Committee (PDF) oversees NQF's portfolio of

[a] This memo is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

prevention and population health measures. Measures in this portfolio focus on healthy lifestyle behaviors and community interventions that improve health and well-being, as well as social and economic conditions.

Draft Report

The Prevention and Population Health Spring 2020 draft report presents the results of the evaluation of two measures considered under the Consensus Development Process (CDP). One was recommended for endorsement and one was not recommended.

The measures were evaluated against the 2019 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	2	0	2
Measures recommended for endorsement	1	0	1
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures not recommended for endorsement or trial use	1	0	1
Measures withdrawn from consideration	0	0	0
Reasons for not recommending	Importance - 1 Scientific Acceptability - 1 Use - 0 Overall - 0 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure – 0	

CSAC Action Required

Pursuant to the CDP, the CSAC is asked to consider endorsement of one candidate consensus measure.

Measures Recommended for Endorsement

- NQF 0032 Cervical Cancer Screening (National Committee for Quality Assurance)

Overall Suitability for Endorsement: Yes-16; No-0

Measures Not Recommended for Endorsement

(See Appendix B for the Committee's votes and rationale)

- NQF 0509 Diagnostic Imaging: Reminder System for Screening Mammograms (American College of Radiology)

Comments and Their Disposition

NQF received three comments from two organizations (including two member organizations) and

individuals pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Prevention and Population Health project webpage.

Comment Themes and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developers, who were invited to respond.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Measure-Specific Comments

Please note that the following comments are abbreviated for the purposes of this memo. Please refer to the comment table for full comment text.

0032 Cervical Cancer Screening (National Committee for Quality Assurance)

The American Geriatrics Society (AGS) wishes to provide comment on measure #0032 Cervical Cancer Screening. Although this measure is endorsed for screening women 18-64 years old, the AGS notes that the population of women age 65 plus who have new sexual partners are excluded from this measure. As this is a growing demographic, it may be worth reconsidering this exclusion. Older women and especially those who have not been screened when they were younger remain at risk for cervical cancer and associated mortality. This measure also aligns well with the current USPSTF recommendation and should also be clinically feasible given the number of options in approach. We do see an ongoing gap in testing for many older adults who have aged out of these recommendations. This gap disproportionately impacts Black and Brown communities. The inclusion of such considerations would not be helpful for this performance measure at this time. However, as stated, if the gap is closed in this younger cohort this would positively impact women aged older than 64 years of age in the next few decades of life. Black women and women in low income families are less likely to be screened for cancer of the cervix and are therefore at disproportionate risk for cancer of the cervix and associated mortality when they are older. Ideally the measure addresses the need for screening in these women who have not been screened when they were younger. However, for that to be meaningful we would need to have access to cancer screening data going back many years and that is not practical at the current time.

Committee Response

Committee acknowledged that the measure specifications align with and follow the current USPSTF recommendations for cervical cancer screening. Additional changes to the measure specifications as indicated by the commentor, would first require changes to the USPSTF recommendations.

Developer Response

Thank you for your comment. The Cervical Cancer Screening measure is based on current recommendations from the US Preventive Services Task Force (USPSTF), which recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. The USPSTF also states that once screening has stopped, it should not resume in women older than 65 years, even if they report having a new sexual partner. Thus, the measure does not assess screening for women age 65 and older.

0509 Diagnostic Imaging: Reminder System for Screening Mammograms (American College of Radiology)

The American Geriatrics Society (AGS) wishes to provide comment on measure #0509 Diagnostic Imaging: Reminder System for Screening Mammograms. We support the decision not to use this measure. Even though there are some data to support reminders for a variety of disease prevention interventions, it is a very contentious issue from a risk management perspective. As long as the data on mammography utilization is being captured, that is sufficient. Although the effects were positive, there is no way to reliably ascertain if all patients have equal access to such reminders. We also agree that without back up measures to ensure that patients are completing the test, the measure would not help the population.

Committee Response

Comment acknowledged and shared with measure developer.

Developer Response

American College of Radiology (ACR) acknowledges that the measure did not meet NQF's must-pass criterion to achieve appropriate empirical validity evidence and plans to re-assess the methodology appropriate for establishing validity and reanalyze the data collected.

0509 Diagnostic Imaging: Reminder System for Screening Mammograms (American College of Radiology)

The American College of Radiology (ACR), measure developer and steward of NQF #0509: Diagnostic Imaging: Reminder System for Screening Mammograms, appreciates NQF's Prevention and Population Health Standing Committee endorsement review. Additionally, we emphasize the importance and evidence supporting the measure for reconsideration for endorsement.

The literature submitted to NQF for the Systematic Review of the Evidence was discussed during the Standing Committee's virtual meeting and summarized in the Draft CDP report. According to the literature, the implementation of a reminder system (like that described in the numerator) established that a reminder call would increase screening mammogram adherence, even despite high baseline screening adherence. The Committee also discussed the improvement of mammography screening adherence, according to a National Academy Press report meta-analysis showing that adherence to regular-interval mammography screening increased by 50% from baseline if reminder systems were used.

We acknowledge that NQF #0509 did not meet NQF's must-pass criterion to achieve appropriate empirical validity evidence based on the testing data submitted, which hypothesized that physicians who perform well on NQF #0509 would also perform well on related measures. Unfortunately, we did not find a strong correlation for performance between these measures using the construct validity method. However, ACR plans to re-assess the methodology appropriate for establishing validity and reanalyze the data collected for NQF #0509. Before this takes place, ACR measure developers will engage with women's imaging experts regarding the Committee's recommendation to examine disparity data as well as determining whether more specificity should be included when capturing the 40 – 49 age cohort. Such specification updates and validity testing methodology could present a strong justification for this measure's re-endorsement."

Committee Response

Comment acknowledged.

Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expression of support or non-support. Appendix C details the expression of support.

Removal of NQF Endorsement

Three measures previously endorsed by NQF have not been re-submitted, and endorsement has been removed.

Measure	Measure Description	Reason for Removal of Endorsement
3154: Informed Participation	Accurately measure coverage among children enrolled in Medicaid or CHIP at the state level and overcome the current inability in the Medicaid Analytic eXtract (MAX) dataset to determine whether a child disenrolled from Medicaid and CHIP due to loss of eligibility (such as due to parental income increase or the acquisition of employer-sponsored insurance, a "good" reason) or failure to appropriately re-enroll (a "bad" reason).	Measure Steward, Children's Hospital of Philadelphia (CHOP), chose to remove measure for consideration
0275: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	Measure Steward (AHRQ) chose to withdraw measure for consideration
0283: Asthma in Younger Adults Admission Rate (PQI 15)	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	Measure Steward (AHRQ) chose to withdraw measure for consideration

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	No	
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	N/A	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	N/A	
Were any measurement gap areas addressed? If so, identify the areas.	No	
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Measures Not Recommended for Endorsement

The table below lists the Committee's vote and rationale for measures not recommended for endorsement.

Legend: H = High; M = Moderate; L = Low; I = Insufficient

Measure	Voting Results	Standing Committee Rationale
0509 Diagnostic Imaging: Reminder System for Screening Mammograms American College of Radiology	**Evidence** H-4; M-11; L-2; I-0 **Gap** H-0; M-2; L-13; I-2 **Reliability** H-8; M-7; L-1; I-1 **Validity** H-0; M-6; L-5; I-6 **Feasibility** N/A **Usability and Use** *Use* N/A *Usability* N/A	Measure did not pass validity, a must pass criterion The Committee also generally felt an important element of validity is that performance is almost perfect, but no empiric data provided for this measure proves that this translates to better mammography screening rates, and, ultimately, improvement in breast cancer rates.

Appendix C: NQF Member Expression of Support Results

No NQF members provided their expression of support or non-support for two measures under consideration.

Appendix D: Details of Measure Evaluation

Measure Recommended

0032 Cervical Cancer Screening

Submission

Description: The percentage of women 21-64 years of age who were screened for cervical cancer using any of the following criteria:

-Women 21-64 years of age who had cervical cytology performed within the last three years.

-Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.

-Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years.

Numerator Statement: The number of women who were screened for cervical cancer.

Denominator Statement: Women 24-64 years of age as of the end of the measurement year.

Exclusions: This measure excludes women who had a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix any time during their medical history through the end of the measurement year.
Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Health Plan
Setting of Care: Outpatient Services
Type of Measure: Process
Data Source: Claims, Electronic Health Data, Paper Medical Records
Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 07/06/2020

1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-14**; **M-2**; **L-0**; **I-0**; 1b. Performance Gap: **H-7**; **M-9**; **L-0**; **I-0**

Rationale:

- The Committee noted that the measure had been updated to comport with the most recent U.S. Preventative Services Task Force guidelines on cervical cancer screening for women, which now includes a third mechanism to meet the measure (cervical high-risk human papillomavirus testing performed within the last five years).
- In response to a question from the Committee, the developer noted that the guidelines indicate 21 years, but the measure has a three-year look back and hence the denominator states women 24-64 years.
- The Committee noted that a performance gap remains, and the developer reported that disparities existed between commercial and Medicaid lines of business. The developer also noted that the literature indicated less screening in Hispanic and Asian populations.

2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-7**; **M-8**; **L-1**; **I-0**; 2b. Validity: **H-0**; **M-14**; **L-2**; **I-0**

Rationale:

- The developer noted it had refined its methodology for signal-to-noise reliability testing to estimate within plan variation, but the new statistic still indicates good reliability (0.94-0.965).
- One Committee member felt the specifications could more clearly state that any one of the methods counted as success for the measures so that implementation would be unambiguous and reliable.
- The Committee noted that the developer provided construct validity to look at a correlation between this measure and two HEDIS measures (*Breast Cancer Screening and Chlamydia Screening in Women*). While some Committee members noted that the correlation between the measure pairs were not strong, but weak to moderate. Other Committee members noted that a meaningful correlation between different screening measures could be appropriate depending on the situation, although correlation to an intermediate outcome or outcome would be better.

0032 Cervical Cancer Screening
• One Committee member inquired whether plans with better screening rates on the measure have better outcomes. The developer noted it did not have that data, although one Committee member noted that we know from the evidence that screening leads to better outcomes.
3. Feasibility: H-15; M-2; L-0; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • The Committee noted that the data elements can be used through an electronic medical record or by chart abstraction. The Committee did not express concern about feasibility.
4. Use and Usability *4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)* 4a. Use: **Pass-17; No Pass-0** *4b. Usability:* **H-4; M-12; L-1; I-0** Rationale: • The Committee noted that the measure is publicly reported and did not express concern about use. • Similarly, the Committee did not express concern about usability.
5. Related and Competing Measures • This measure is related to NQF #0579 *Annual Cervical Cancer Screening* of follow-up for high-risk women. Both measures focus on cervical cancer screening, but the denominator for #0579 is high-risk women. The developer states the exclusions are aligned. • Because the measures focus on different denominator populations, no vote was taken by the Committee.
6. Standing Committee Recommendation for Endorsement: **Y-16**; **N-0**
7. Public and Member Comment • The American Geriatrics Society (AGS) provided a comment on the inclusions of this measure, the population of women age 65 plus who have new sexual partners are excluded from this measure. As specified, the measure is for screening women 18 – 64 years old. The comment further explains that there is an ongoing gap in testing for many older adults who have aged out of these recommendations and this disproportionately impacts Black and Brown communities. In addition, older women and especially those who have not been screened when they were younger remain at risk for cervical cancer and associated mortality.
8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
9. Appeals

Measure Not Recommended

0509 Diagnostic Imaging: Reminder System for Screening Mammograms
Submission
Description: Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram **Numerator Statement**: Patients whose information is entered into a reminder system with a target due date for the next mammogram **Denominator Statement**: All patients undergoing a screening mammogram **Exclusions**: Documentation of medical reason(s) for not entering patient information into a reminder system (eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s))

0509 Diagnostic Imaging: Reminder System for Screening Mammograms

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Clinician: Individual
Setting of Care: Inpatient/Hospital, Outpatient Services
Type of Measure: Structure
Data Source: Claims, Registry Data
Measure Steward: American College of Radiology

STANDING COMMITTEE MEETING 07/06/2020

1. Importance to Measure and Report: <u>The measure did not meet the importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-4**; **M-11**; **L-2**; **I-0**; 1b. Performance Gap: **H-0**; **M-2**; **L-13**; **I-2**

<u>Rationale</u>:

- The Committee expressed concern that the measure involves entering a reminder for the patient's next screening mammogram into the provider's reminder system, and does not ensure the patient actually received the reminder nor actually returned for the mammogram, which is the most important component.
- In response to a question about the evidence specific to reminder systems (vs. the importance of receiving mammograms), the developer noted that the original submission included a recommendation for reminder systems by the Community Services Task Force. It also noted that it had conducted a systematic review of the quality, quantity, and consistency of evidence to demonstrate reminder systems increase mammogram screening.
- The developer noted it also had provided updated evidence, a 2018 randomized controlled trial that examined interventions and noted a reminder system can increase screening mammogram adherence.
- The Committee noted that the evidence provided indicated mammography screening improved, and one Committee member cited a National Academy Press report that cited a meta-analysis that showed receipt of mammography increased by 50% from baseline if reminder systems were used.
- The Committee noted that there was no information provided related to disparities. In response to the Committee's query, the developer stated it was not aware of disparities related to the use of a reminder system for mammography or the receipt of a reminder, but it is aware of disparities (e.g., by race, ethnicity, and income status) related to receiving a mammogram. One Committee member noted there was evidence of disparities in the use of reminder systems for other areas, and it would have been useful for the developer indicated this. The Committee emphasized that providing evidence on disparities would be valuable and might be part of the rationale to continue endorsement.
- The Committee voted to consider the measure for Reserve Status (Y-14; N-3).

2. Scientific Acceptability of Measure Properties: <u>The measure did not meet the scientific acceptability criteria; failed on validity</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-8**; **M-7**; **L-1**; **I-1**; 2b. Validity: **H-0**; **M-6**; **L-5**; **I-6**

<u>Rationale</u>:

- Some Committee members expressed no concerns about the empiric reliability (signal-to-noise) testing, which yielded a result of 0.98; the developer stated this indicated high reliability by convention.
- Other Committee members questioned the measure's reliability because of the variability of the timing of the due date for the next mammogram that is entered into the system. They questioned the reliability given this variability in screening intervals by age. For example, how can reliable comparisons in performance be made if one site based it on one policy and another on a different policy for time intervals for the reminder?
- Especially of concern to the Committee in this regard is the 40-49 year age cohort. It was noted that the U.S. Preventive Services Task Force does not specify a time period for routine screening for this cohort, yet this is an all-age group measure with specific evidence-based guidance for the timing of reminders for other age cohorts.

0509 Diagnostic Imaging: Reminder System for Screening Mammograms

- The developer indicated that American College of Radiology (ACR) has guidelines, and there also are site-specific and patient-specific policies, but there is no specific guidance for this age group. The developer acknowledged that the time interval is variable by age cohort, but stated the evidence showed that the greater need is to have the reminder system in place for all ages.
- One Committee member asked whether patient opt out of the reminder was an option, and the developer responded it was not.
- For validity testing, the Committee noted that the developer's empiric testing did not seek to correlate performance on this measure with improved mammography rates. The developer performed correlation analyses with other process measures, hypothesizing physicians who did well on this measure also would do well on the other measures. The Committee noted the developer found no correlation to performance on these measures.
- The Committee also generally felt an important element of validity is that performance is almost perfect, but no empiric data provided for this measure proves that this translates to better mammography screening rates, and, ultimately, improvement in breast cancer rates. Other Committee members noted that there is good evidence that mammography screening improves breast cancer outcomes so a measure that promotes this will improve outcomes.
- The Committee did not pass the measure on validity.

3. Feasibility: H-X; M-X; L-X; I-X <u>The Standing Committee did not vote on this criterion since the measure did not pass scientific acceptability</u>

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

4. Use and Usability <u>The Standing Committee did not vote on these criteria since the measure did not pass scientific acceptability</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-X; No Pass-X** *4b. Usability:* **H-X; M-X; L-X; I-X**

5. Related and Competing Measures

- The developer identified #NQF 2372 *Breast Cancer Screening* (health plan level) as a related measure. The Committee did not discuss this criterion because the measure did not meet the scientific acceptability criterion.

6. Standing Committee Recommendation for Endorsement: **Y-X**; **N-X**

The Standing Committee did not vote on an endorsement recommendation since the measure did not pass scientific acceptability, a must-pass criterion.

7. Public and Member Comment

- The American Geriatrics Society (AGS) provided a comment not in support of this measure. The comment mentioned that reminders for disease prevention can be a contentious issue from a risk management perspective as there is no way to reliably ascertain if all patients have equal access to such reminders. Ultimately, the measure would not help the population.
- The American College of Radiology (ACR), provided comments addressing a portion of the Standing Committee's feedback, mentioning their intensions to address the associated issues in the near future. The comment emphasized the criterion of importance and evidence that was discussed to support the measure as a reason for reconsideration for endorsement. Specifically, it was noted that the Committee discussed the improvement of mammography screening adherence, according to a National Academy Press report meta-analysis showing that adherence to regular-interval mammography screening increased by 50% from baseline if reminder systems were used. ACR acknowledged that the measure did not meet NQF's must-pass criterion to achieve appropriate empirical validity evidence based on the testing data submitted, which hypothesized that physicians who perform well on NQF #509 would also perform well on related measures. They plan to re-assess the methodology appropriate for establishing validity and reanalyze the data collected for NQF #509.

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

0509 Diagnostic Imaging: Reminder System for Screening Mammograms
9. Appeals

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Prevention and Population Health Spring 2020 Review Cycle

CSAC Review and Endorsement

November 18, 2020

Funded by the Centers for Medicare and Medicaid Services under contract HHSM 500 2017 00060I Task Order HHSM 500 T0001.

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Standing Committee Recommendations

- Two measures reviewed for Spring 2020
- One measure recommended for endorsement
  - **NQF 0032** Cervical Cancer Screening (Maintenance Measure)
- One measure not recommended for endorsement
  - **NQF 0509** Diagnostic Imaging: Reminder System for Screening Mammograms (Maintenance Measure)

Overarching Issues

- Disparities Data
  - The Committee noted that collecting data for measures in a manner that permits analysis for disparities should be considered as a requirement and, furthermore reporting on inequities, if identified, should also be required.

Public and Member Comment and Member Expressions of Support

- Three comments received from two member organizations
  - Supportive of recommendation to not endorse NQF 0509
  - Supportive with concerns about exclusion of women age 65 plus who have new sexual partners; gap in testing disproportionately impacts Black and Brown communities
  - Comment from developer expressing interest in resubmitting for endorsement
- No NQF member expressions of support or non-support received

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Questions?

- Project team:
  - Nicole Williams, MPH, Director
  - Chris Dawson, MHA, Manager
  - Isaac Sakyi, MSGH, Analyst
  - Mike DiVecchia, MBA, PMP, Project Manager
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- Project page: http://www.qualityforum.org/Prevention_and_Population_Health.aspx

- Email: populationhealth@qualityforum.org

THANK YOU.

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Prevention and Population Health Spring 2020 Cycle: CDP Report

DRAFT REPORT FOR CSAC
NOVEMBER 18, 2020

This report is funded by the Centers for Medicare and Medicaid Services under contract HHSM-500-2017-00060I –75FCMC19F0007.

http://www.qualityforum.org

Contents

Executive Summary

Traditionally, medical care has been the primary focus of efforts to improve the health and well-being of individuals and populations. As a result, nearly all national health expenditures have been attributed to healthcare services. Yet, medical care has a relatively small influence on health outcomes when compared to interventions that address smoking, lower educational attainment, poverty, poor diet, and physical environmental hazards (e.g., unsafe housing and polluted air).[1] There is growing recognition of the role of social determinants of health (SDOH) in influencing health outcomes. Maintaining and improving the health and well-being of individuals and populations will require a multidisciplinary, multifactorial approach to address SDOH.

Performance measures are needed to assess improvements in population health as well as the extent to which healthcare stakeholders are using evidence-based strategies (e.g., prevention programs, screening, and community needs assessments). To support this effort, the National Quality Forum (NQF) endorses and maintains performance measures related to prevention and population health through a multistakeholder consensus development process. The purpose of this project was to review prevention and population health measures submitted for endorsement or undergoing endorsement maintenance during the spring 2020 cycle.

NQF's prevention and population health portfolio of measures includes measures for health-related behaviors to promote healthy living; community-level indicators of health and disease; social, economic, and environmental determinants of health; primary prevention and/or screening; and oral health.

For this project, the Prevention and Population Health Standing Committee evaluated two measures undergoing maintenance review against the NQF's standard evaluation criteria. The Committee recommended one measure for endorsement and one measure was not recommended for endorsement.

The Committee recommended the following measure for endorsement:

- **NQF 0032** Cervical Cancer Screening (National Committee for Quality Assurance)

The Committee did not recommend the following measure:

- **NQF 0509** Diagnostic Imaging: Reminder System for Screening Mammograms (American College of Radiology)

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

The United States continues to lag behind other nations in key population health indicators, such as infant mortality, obesity, and life expectancy, despite spending more on healthcare than any other nation in the world.[2] Population health describes the "health outcomes of a group of individuals, including the distribution of such outcomes within the group."[3] Both medical care and SDOH influence health outcomes. SDOH are known as the conditions in the places where people live, learn, work, and play; specific factors include availability of safe housing and local food markets, access to healthcare services, and culture. *Healthy People 2020* highlights the importance of addressing SDOH by including "social and physical environments that promote good health for all" as one of the four overarching goals for the decade.[4] Nearly 60 percent of deaths in the United States have been attributed to SDOH,[5] yet less than 5 percent of national health expenditures have been attributed to prevention services.[6] Furthermore, healthcare systems are increasingly expanding their roles to collaborate with patients and communities to better address SDOH.

Performance measurement is necessary to assess whether healthcare stakeholders are using strategies to increase prevention and improve population health. Strengthening measurement of prevention and population health will require joint efforts from communities, public health entities, and other non-healthcare stakeholders (e.g., education, transportation, and employment) that influence health outcomes. A large body of evidence demonstrates that targeted programs and policies can prevent disease, increase productivity, and yield billions of dollars in savings for the U.S. healthcare system. The United States can reduce the incidence of morbidity and premature mortality by identifying the right measures and implementing evidence-based interventions.

To support this goal, NQF maintains a portfolio of measures endorsed through a multistakeholder consensus development process and has developed best practices for prevention and population health. NQF's prevention and population health portfolio includes measures that assess the promotion of healthy behaviors, community-level indicators of health, oral health, and primary prevention strategies. For example, NQF has endorsed several measures related to immunizations and preventive health screenings that are widely used in public reporting and accountability programs.

This project seeks to identify and endorse measures that can be used to assess prevention and population health in both healthcare and community settings. It also focuses on the assessment of disparities in health outcomes. The measures reviewed during the spring 2020 cycle focused on screening for cervical cancer and a reminder system for screening for mammograms. These measures promote population health and lower morbidity and cost over an individual's lifetime.

NQF Portfolio of Performance Measures for Prevention and Population Health Conditions

The Prevention and Population Health Standing Committee (Appendix C) oversees the majority of NQF's portfolio of prevention and population health measures (Appendix B), which includes measures for immunization, oral health, and cancer screening. This portfolio contains 32 measures: 21 process and 11 outcome measures (see Table 1 below).

Table 1. NQF Prevention and Population Health Portfolio of Measures

	Process	Outcome
Immunization	8	0
Pediatric Dentistry	4	1
Weight/BMI	1	0
Diabetes	0	4
Admission Rates	0	5
Cancer Screening	4	0
Cardiovascular/Pulmonary	1	1
Well-Child Visits	2	0
Colonoscopy	1	0
Total	21	11

Some measures related to prevention and population health are assigned to other projects. These include various diabetes assessment and screening measures (Behavioral Health and Substance Use), HIV viral load (Primary Care and Chronic Illness), Angiotensin-converting enzyme inhibitor/Angiotensin II receptor blockers (ACEI/ARB) medication measures (Cardiovascular), asthma admission rates (All-Cause Admissions and Readmissions), and one population-based resource use measure (Cost and Efficiency).

Prevention and Population Health Measure Evaluation

On July 6 and 7, 2020, the Prevention and Population Health Standing Committee evaluated two measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Prevention and Population Health Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	2	0	2
Measures recommended for endorsement	1	0	1
Measures not recommended for endorsement	1	0	1

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 11, 2020 and closed on September 14, 2020. Pre-meeting commenting closed on June 19, 2020. As of that date, no comments were submitted.

Comments Received After Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on September 14, 2020. Following the Committee's evaluation of the measures under consideration, NQF received three comments from two member organizations pertaining to the draft report and to the measures under consideration. All comments for each measure under consideration have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. No NQF members provided their expression of support or non-support.

Overarching Issues

During the Standing Committee's discussion of the measures, one overarching issue emerged that was factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Disparities Data

The Committee emphasized the importance of providing disparities information for measures. Of particular concern is a lack of disparities performance data for process measures where there are known disparities in outcomes related to the process measure. Specifically, the Committee noted that collecting data for measures in a manner that permits analysis for disparities should be considered as a requirement and, furthermore reporting on inequities, if identified, should also be required. The Committee viewed the lack of such an approach as a lost opportunity to use measurement to reduce inequities in healthcare quality. It also noted that a measure that appears "topped out" in performance might have underlying population disparities. These disparities may be masked by a national average and the measure may be appropriate for continued endorsement, but it is impossible to discern if disparities data are not provided for the measure.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Cancer Screening

0032 Cervical Cancer Screening (National Committee for Quality Assurance): Recommended

Description: The percentage of women 21-64 years of age who were screened for cervical cancer using any of the following criteria:

- Women 21-64 years of age who had cervical cytology performed within the last three years.
- Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years.
- Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years.

Measure Type: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Data, Paper Medical Records

The Standing Committee recommended the measure for continued endorsement. The Committee began its discussion with evidence, which has been updated to meet the 2018 United States Preventive Services Task Force guidelines. It was specifically noted that this measure now encompasses three ways of screening for cervical cancer, whereas previously there were only two. The Committee agreed with the updated evidence presented and noted the specifications aligned with it. During the discussion of performance gap, the Committee reviewed the new information on disparities provided by the developer; literature has found less screening among Hispanic and Asian populations. The performance data differential among commercial and Medicaid plans also was discussed. Although acknowledging a gap, members of the Committee expressed concerns about whether disparities are hidden based on how the data are aggregated and reported within health plans and encouraged a more systematic and thorough approach to collecting disparities data for the measure.

The reliability and validity testing were discussed by the Committee. The reliability statistics of 1.0 for commercial plans (402 plans) and 0.99 for Medicaid plans (245 plans) suggest the measure has high reliability, to which the Committee agreed. The developer also noted it had developed a new signal-to-noise approach that examined within plan reliability, which also yielded reliability statistics exceeding 0.90. During the discussion on validity, the Committee reviewed the developer's construct validity testing, which showed a correlation between this measure and two other Healthcare Effectiveness Data and Information Set (HEDIS) process measures (*Breast Cancer Screening and Cervical Cancer Screening*), with the developer hypothesizing that organizations that performed well on this measures should perform well on the other two. The specific range of the correlation coefficients (i.e., 0.32-0.67 for commercial and Medicaid plans) was discussed by the Committee and noted by the developer as moderate. Some Committee members questioned the measures used in the construct validity testing, indicating a preference that the measure be correlated with an outcome. Other Committee members, however, stated that the approach taken and use of other screening measures was appropriate.

The Committee also discussed feasibility, use, and usability and did not express any concerns.

0509 Diagnostic Imaging: Reminder System for Screening Mammograms (American College of Radiology): Not Recommended

Description: Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram; **Measure Type**: Structure; **Level of Analysis**: Clinician: Individual; **Setting of Care**: Inpatient/Hospital, Outpatient Services; **Data Source**: Claims, Registry Data

The Standing Committee did not vote on the recommendation for endorsement; the measure did not pass the validity criterion—a must-pass criterion. The Committee began its discussion with evidence, which was updated by the developer with a 2018 study of a randomized controlled trial comparing three outreach interventions to promote screening mammography that reinforced the previous evidence. While the presented evidence was accurate, the Committee discussed whether it showed empirical proof that a reminder system leads to higher screening and, more importantly, improved outcomes. One report from the National Academy Press was cited by a Committee member as showing that mammogram screening increased by 50% when coupled with a reminder system.

At the outset of the discussion on performance gap, NQF noted the preliminary analysis rating of low for this criterion, which indicates the measure is topped out (mean performance reported was 99.6%). NQF noted that such a high-performance rate allowed the Committee to consider this measure for Reserve Status. The purpose of Reserve Status is to retain endorsement of reliable and valid measures that have overall high levels of performance so that performance can be monitored, as necessary, to ensure that performance does not decline. NQF noted that Reserve Status should only be applied to highly credible, reliable, and valid measures that have high levels of performance due to quality improvement actions (e.g., not due to documentation practices only).

During the discussion on performance gap, Committee members asked about the availability of disparities data, but the developer indicated it did not have that information specific to this measure. The Committee further noted that providing information on disparities would be valuable, as there might be a rationale to continue this measure for endorsement if disparities were present. The Committee concluded that the performance gap was low and the measure should be eligible for Reserve Status. The Committee reviewed and discussed the measure's reliability; a beta-binomial model measuring the ratio of signal to noise was provided showing a reliability statistic of 0.98 (79,450 physicians) for physicians having a minimum of 10 events in the period 2015-2018, suggesting the measure has high reliability. One Committee member questioned the variability in guidelines for mammography screening by age group (e.g., screening or re-screening for a patient age 40-49 has a different recommendation than a patient who is 50 and older), and how this variability would be taken into account when recording this measure. The developer mentioned that determination of screening or rescreening is up to the provider and varies by facility and patient circumstances; the lack of specificity was purposeful.

During the discussion on validity, NQF noted the preliminary analysis rating was insufficient. NQF stated that the developer conducted construct validity, calculating Pearson's coefficients. NQF noted, however, that the developer was unable to find a correlation of this measure with two other process measures (including an NQF-endorsed measure), having hypothesized that good performance on this measure

likely indicates physicians who follow guidelines are working within practices that have good systems for tracking patients or do not unnecessarily recall patients. The Committee discussed the comparability across physicians implementing this measure, since that also could be a validity issue if each provider is using a slightly different recommendation. For example, while the data on performance could be high among providers following the same recommendations, the rates could be very different when comparing the same measure across providers/facilities. The Committee did not pass this measure on validity.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Recommended

0032 Cervical Cancer Screening
Submission | Specifications
Description: The percentage of women 21-64 years of age who were screened for cervical cancer using any of the following criteria: -Women 21-64 years of age who had cervical cytology performed within the last three years. -Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. -Women 30-64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years. **Numerator Statement**: The number of women who were screened for cervical cancer. **Denominator Statement**: Women 24-64 years of age as of the end of the measurement year. **Exclusions**: This measure excludes women who had a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix any time during their medical history through the end of the measurement year. **Adjustment/Stratification**: No risk adjustment or risk stratification **Level of Analysis:** Health Plan **Setting of Care:** Outpatient Services **Type of Measure**: Process **Data Source**: Claims, Electronic Health Data, Paper Medical Records **Measure Steward**: National Committee for Quality Assurance
STANDING COMMITTEE MEETING 07/06/2020 **1. Importance to Measure and Report: The measure meets the importance criteria** (1a. Evidence, 1b. Performance Gap) 1a. Evidence: **H-14**; **M-2**; **L-0**; **I-0**; 1b. Performance Gap: **H-7**; **M-9**; **L-0**; **I-0** Rationale: • The Committee noted that the measure had been updated to comport with the most recent U.S. Preventative Services Task Force guidelines on cervical cancer screening for women, which now includes a third mechanism to meet the measure (cervical high-risk human papillomavirus testing performed within the last five years). • In response to a question from the Committee, the developer noted that the guidelines indicate 21 years, but the measure has a three-year look back and hence the denominator states women 24-64 years. • The Committee noted that a performance gap remains, and the developer reported that disparities existed between commercial and Medicaid lines of business. The developer also noted that the literature indicated less screening in Hispanic and Asian populations.
2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity 2a. Reliability: **H-7**; **M-8**; **L-1**; **I-0**; 2b. Validity: **H-0**; **M-14**; **L-2**; **I-0** Rationale: • The developer noted it had refined its methodology for signal-to-noise reliability testing to estimate within plan variation, but the new statistic still indicates good reliability (0.94-0.965). • One Committee member felt the specifications could more clearly state that any one of the methods counted as success for the measures so that implementation would be unambiguous and reliable.

0032 Cervical Cancer Screening
• The Committee noted that the developer provided construct validity to look at a correlation between this measure and two HEDIS measures (*Breast Cancer Screening and Chlamydia Screening in Women*). While some Committee members noted that the correlation between the measure pairs were not strong, but weak to moderate. Other Committee members noted that a meaningful correlation between different screening measures could be appropriate depending on the situation, although correlation to an intermediate outcome or outcome would be better. • One Committee member inquired whether plans with better screening rates on the measure have better outcomes. The developer noted it did not have that data, although one Committee member noted that we know from the evidence that screening leads to better outcomes.
3. Feasibility: H-15; M-2; L-0; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)* Rationale: • The Committee noted that the data elements can be used through an electronic medical record or by chart abstraction. The Committee did not express concern about feasibility.
4. Use and Usability *4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)* 4a. Use: **Pass-17; No Pass-0** *4b. Usability:* **H-4; M-12; L-1; I-0** Rationale: • The Committee noted that the measure is publicly reported and did not express concern about use. • Similarly, the Committee did not express concern about usability.
5. Related and Competing Measures • This measure is related to NQF #0579 *Annual Cervical Cancer Screening* of follow-up for high-risk women. Both measures focus on cervical cancer screening, but the denominator for #0579 is high-risk women. The developer states the exclusions are aligned. • Because the measures focus on different denominator populations, no vote was taken by the Committee.
6. Standing Committee Recommendation for Endorsement: **Y-16**; **N-0**
7. Public and Member Comment • The American Geriatrics Society (AGS) provided a comment on the inclusions of this measure, the population of women age 65 plus who have new sexual partners are excluded from this measure. As specified, the measure is for screening women 18 – 64 years old. The comment further explains that there is an ongoing gap in testing for many older adults who have aged out of these recommendations and this disproportionately impacts Black and Brown communities. In addition, older women and especially those who have not been screened when they were younger remain at risk for cervical cancer and associated mortality.
8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
9. Appeals

Measure Not Recommended

0509 Diagnostic Imaging: Reminder System for Screening Mammograms

Submission | Specifications

Description: Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

Numerator Statement: Patients whose information is entered into a reminder system with a target due date for the next mammogram

Denominator Statement: All patients undergoing a screening mammogram

Exclusions: Documentation of medical reason(s) for not entering patient information into a reminder system (eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s))

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Clinician: Individual

Setting of Care: Inpatient/Hospital, Outpatient Services

Type of Measure: Structure

Data Source: Claims, Registry Data

Measure Steward: American College of Radiology

STANDING COMMITTEE MEETING 07/06/2020

1. Importance to Measure and Report: The measure did not meet the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-4**; **M-11**; **L-2**; **I-0**; 1b. Performance Gap: **H-0**; **M-2**; **L-13**; **I-2**

Rationale:

- The Committee expressed concern that the measure involves entering a reminder for the patient's next screening mammogram into the provider's reminder system, and does not ensure the patient actually received the reminder nor actually returned for the mammogram, which is the most important component.
- In response to a question about the evidence specific to reminder systems (vs. the importance of receiving mammograms), the developer noted that the original submission included a recommendation for reminder systems by the Community Services Task Force. It also noted that it had conducted a systematic review of the quality, quantity, and consistency of evidence to demonstrate reminder systems increase mammogram screening.
- The developer noted it also had provided updated evidence, a 2018 randomized controlled trial that examined interventions and noted a reminder system can increase screening mammogram adherence.
- The Committee noted that the evidence provided indicated mammography screening improved, and one Committee member cited a National Academy Press report that cited a meta-analysis that showed receipt of mammography increased by 50% from baseline if reminder systems were used.
- The Committee noted that there was no information provided related to disparities. In response to the Committee's query, the developer stated it was not aware of disparities related to the use of a reminder system for mammography or the receipt of a reminder, but it is aware of disparities (e.g., by race, ethnicity, and income status) related to receiving a mammogram. One Committee member noted there was evidence of disparities in the use of reminder systems for other areas, and it would have been useful for the developer indicated this. The Committee emphasized that providing evidence on disparities would be valuable and might be part of the rationale to continue endorsement.
- The Committee voted to consider the measure for Reserve Status (Y-14; N-3).

2. Scientific Acceptability of Measure Properties: The measure did not meet the scientific acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity

2a. Reliability: **H-8**; **M-7**; **L-1**; **I-1**; 2b. Validity: **H-0**; **M-6**; **L-5**; **I-6**

Rationale:

0509 Diagnostic Imaging: Reminder System for Screening Mammograms

- Some Committee members expressed no concerns about the empiric reliability (signal-to-noise) testing, which yielded a result of 0.98; the developer stated this indicated high reliability by convention.
- Other Committee members questioned the measure's reliability because of the variability of the timing of the due date for the next mammogram that is entered into the system. They questioned the reliability given this variability in screening intervals by age. For example, how can reliable comparisons in performance be made if one site based it on one policy and another on a different policy for time intervals for the reminder?
- Especially of concern to the Committee in this regard is the 40-49 year age cohort. It was noted that the U.S. Preventive Services Task Force does not specify a time period for routine screening for this cohort, yet this is an all-age group measure with specific evidence-based guidance for the timing of reminders for other age cohorts.
- The developer indicated that American College of Radiology (ACR) has guidelines, and there also are site-specific and patient-specific policies, but there is no specific guidance for this age group. The developer acknowledged that the time interval is variable by age cohort, but stated the evidence showed that the greater need is to have the reminder system in place for all ages.
- One Committee member asked whether patient opt out of the reminder was an option, and the developer responded it was not.
- For validity testing, the Committee noted that the developer's empiric testing did not seek to correlate performance on this measure with improved mammography rates. The developer performed correlation analyses with other process measures, hypothesizing physicians who did well on this measure also would do well on the other measures. The Committee noted the developer found no correlation to performance on these measures.
- The Committee also generally felt an important element of validity is that performance is almost perfect, but no empiric data provided for this measure proves that this translates to better mammography screening rates, and, ultimately, improvement in breast cancer rates. Other Committee members noted that there is good evidence that mammography screening improves breast cancer outcomes so a measure that promotes this will improve outcomes.
- The Committee did not pass the measure on validity.

3. Feasibility: H-X; M-X; L-X; I-X <u>The Standing Committee did not vote on this criterion since the measure did not pass scientific acceptability</u>

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

4. Use and Usability <u>The Standing Committee did not vote on these criteria since the measure did not pass scientific acceptability</u>

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-X; No Pass-X** *4b. Usability:* **H-X; M-X; L-X; I-X**

5. Related and Competing Measures

- The developer identified #NQF 2372 *Breast Cancer Screening* (health plan level) as a related measure. The Committee did not discuss this criterion because the measure did not meet the scientific acceptability criterion.

6. Standing Committee Recommendation for Endorsement: **N/A**

The Standing Committee did not vote on an endorsement recommendation since the measure did not pass scientific acceptability, a must pass criterion.

7. Public and Member Comment

0509 Diagnostic Imaging: Reminder System for Screening Mammograms
• The American Geriatrics Society (AGS) provided a comment not in support of this measure. The comment mentioned that reminders for disease prevention can be a contentious issue from a risk management perspective as there is no way to reliably ascertain if all patients have equal access to such reminders. Ultimately, the measure would not help the population. • The American College of Radiology (ACR), provided comments addressing a portion of the Standing Committee's feedback, mentioning their intensions to address the associated issues in the near future. The comment emphasized the criterion of importance and evidence that was discussed to support the measure as a reason for reconsideration for endorsement. Specifically, it was noted that the Committee discussed the improvement of mammography screening adherence, according to a National Academy Press report meta-analysis showing that adherence to regular-interval mammography screening increased by 50% from baseline if reminder systems were used. ACR acknowledged that the measure did not meet NQF's must-pass criterion to achieve appropriate empirical validity evidence based on the testing data submitted, which hypothesized that physicians who perform well on NQF #509 would also perform well on related measures. They plan to re-assess the methodology appropriate for establishing validity and reanalyze the data collected for NQF #509.
8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
9. Appeals

Appendix B: Prevention and Population Health Portfolio—Use in Federal Programs[1]

NQF #	Title	Federal Programs: Finalized or Implemented
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Merit-Based Incentive Payment System (MIPS) Program; Medicaid; Marketplace Quality Rating System (QRS)
0032	Cervical Cancer Screening (CCS)	MIPS Program; Medicaid; QRS
0034	Colorectal Cancer Screening (COL)	Medicare Shared Savings Program (MSSP); MIPS Program; QRS; Medicare Part C Star Rating
0038	Childhood Immunization Status (CIS)	MIPS Program; QRS (Implemented)
0041	Preventive Care and Screening: Influenza Immunization	MSSP; MIPS Program
0041e	Preventive Care and Screening: Influenza Immunization	MIPS Program; Medicaid Promoting Interoperability Program for Eligible Professionals
0226	Influenza Immunization in the ESRD Population (Facility Level)	No federal program usage specified for this measure.
0272	Diabetes Short-Term Complications Admission Rate (PQI 01)	Medicaid
0273	Perforated Appendix Admission Rate (PQI 02)	No federal program usage specified for this measure.
0274	Diabetes Long-Term Complications Admission Rate (PQI 03)	No federal program usage specified for this measure.
0275	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	Medicaid
0277	Congestive Heart Failure Rate (PQI 08)	Medicaid
0279	Community Acquired Pneumonia Admission Rate (PQI 11)	No federal program usage specified for this measure.
0280	Dehydration Admission Rate (PQI 10)	No federal program usage specified for this measure.

[1] Per CMS Measures Inventory Tool as of 07/14/2020

0281	Urinary Tract Infection Admission Rate (PQI 12)	No federal program usage specified for this measure.
0283	Asthma in Younger Adults Admission Rate (PQI 15)	Medicaid
0285	Lower-Extremity Amputation among Patients with Diabetes Rate (PQI 16)	No federal program usage specified for this measure.
0431	Influenza Vaccination Coverage Among Healthcare Personnel	Hospital Compare; Hospital Inpatient Quality Reporting; Inpatient Rehabilitation Facility Quality Reporting; Long-Term Care Hospital Quality Reporting; Home Health Value Based Purchasing; Inpatient Rehabilitation Facility Compare; Long-Term Care Hospital Compare
0509	Diagnostic Imaging: Reminder System for Screening Mammograms	No federal program usage specified for this measure.
0638	Uncontrolled Diabetes Admission Rate (PQI 14)	No federal program usage specified for this measure.
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Ambulatory Surgical Center Quality Reporting; Hospital Compare; Hospital Outpatient Quality Reporting; MIPS Program
0680	Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (short stay)	Inpatient Rehabilitation Facility Quality Reporting (Proposed); Long-Term Care Hospital Quality Reporting
0681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay)	Nursing Home Compare; Nursing Home Quality Initiative
1407	Immunizations for Adolescents	MIPS Program; Medicaid; QRS
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Medicaid; QRS
2020	Adult Current Smoking Prevalence	No federal program usage specified for this measure.
2372	Breast Cancer Screening	Medicare Part C Star Rating; MIPS Program; Medicaid; QRS
2508	Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk, Dental Services	Medicaid

Appendix C: Prevention and Population Health Standing Committee and NQF Staff

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Appendix D: Measure Specifications

	0032 Cervical Cancer Screening
Steward	National Committee for Quality Assurance
Description	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: -Women 21–64 years of age who had cervical cytology performed within the last 3 years. -Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. -Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Type	Process
Data Source	Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation 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.
Level	Health Plan
Setting	Outpatient Services
Numerator Statement	The number of women who were screened for cervical cancer.
Numerator Details	ADMINISTRATIVE: Number of women who were screened for cervical cancer through either of the following criteria: -Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year. -Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test. NOTE: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore additional methods to identify cotesting are not necessary. See attached value sets. MEDICAL RECORD: Number of women who were screened for cervical cancer through either of the following criteria: -Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following: A note indicating the date when the cervical cytology was performed; and The result or finding. Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

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	Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. NOTE: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test. -Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following: A note indicating the date when the hrHPV test was performed. Generic documentation of “HPV test” can be counted as evidence of hrHPV test; and The results or findings. Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. NOTE: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.
Denominator Statement	Women 24-64 years of age as of the end of the measurement year.
Denominator Details	Use administrative data to identify all women 24-64 years of age as of the end of the measurement year.
Exclusions	This measure excludes women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.
Exclusion details	ADMINISTRATIVE: Exclude women who had evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set, Hysterectomy with No Residual Cervix Value Set) any time during their medical history through the end of the measurement year. See attached value sets. MEDICAL RECORD: Exclude women where there is documentation in the medical record of “complete,” “total” or “radical” abdominal or vaginal hysterectomy any time during their medical history through the end of the measurement year. The following also meet criteria: -Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy.” -Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening. Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population: identify women 24-64 years of age as of the end of the measurement year. Step 2: Exclude women who had evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year. Step 3: Determine the numerator: identify the number of women who were screened for cervical cancer following the instructions in the numerator details listed in Section S.5.

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	Step 4: Divide the numerator from Step 3 by the denominator from Step 2 to determine the rate. 123834| 140881| 122107| 150289
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	0509 Diagnostic Imaging: Reminder System for Screening Mammograms
Steward	American College of Radiology
Description	Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram
Type	Structure
Data Source	Claims, Registry Data We're using data submitted to CMS through claims and registries for the Merit-based Incentives Payment Program.
Level	Clinician : Individual
Setting	Inpatient/Hospital, Outpatient Services
Numerator Statement	Patients whose information is entered into a reminder system with a target due date for the next mammogram
Numerator Details	Numerator Note: The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier, patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram. Use of the reminder system is not required to be documented within the final report to meet performance for this measure. Performance Met: Patient information entered into a reminder system with a target due date for the next mammogram (7025F) Performance Not Met: Patient Information not entered into a reminder system, reason not otherwise specified (7025F with 8P)
Denominator Statement	All patients undergoing a screening mammogram
Denominator Details	Denominator Criteria (Eligible Cases): All patients, regardless of age AND Diagnosis for mammogram screening (ICD-10-CM): Z12.31 Diagnosis for mammogram screening (ICD-9-CM)[for use 1/1/2015-9/30/2015]: V76.11, V76.12 AND Patient procedure during the performance period (CPT or HCPCS): 77067
Exclusions	Documentation of medical reason(s) for not entering patient information into a reminder system [(eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s)]
Exclusion details	Documentation of medical reason(s) for not entering patient information into a reminder system (e.g., further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s) (7025F with 1P)

	0509 Diagnostic Imaging: Reminder System for Screening Mammograms
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, sex, and payer.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure. 108475| 145989| 141015| 142351
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Appendix E: Related and Competing Measures (Tabular)

Comparison of NQF #0032 and NQF #0579

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
Steward	National Committee for Quality Assurance	Resolution Health, Inc.
Description	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: -Women 21–64 years of age who had cervical cytology performed within the last 3 years. -Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. -Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.	This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year.
Type	Process	Process
Data Source	Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation 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. No data collection instrument provided Attachment 0032_CCS_Spring_2020_Value_Sets.xlsx	Claims (Only), Pharmacy Collection Instrument - administrative claims. URL Attachment 0579- 2a1.30. Data Dictionary or Code Table.pdf
Level	Health Plan	Population : Community, County or City, Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System
Setting	Outpatient Services	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office
Numerator Statement	The number of women who were screened for cervical cancer.	Patients in the denominator who had a cervical CA screen during the measurement year
Numerator Details	ADMINISTRATIVE: Number of women who were screened for cervical cancer through either of the following criteria: -Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.	>=1 procedure claim for a cervical cancer screen during the measurement year. Codes with descriptors: '0923 Other Diagnostic Services HSREV '88141 CYTOPATH C/V INTERPRET CPT4 '88142 CYTOPATH C/V THIN LAYER CPT4 '88143 CYTOPATH CERV/VAG; W/MNL SCR-RESCR CPT4 '88147 CYTOPATH C/V AUTOMATED CPT4 '88148 CYTOPATH C/V AUTO RESCREEN CPT4

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
	-Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test. NOTE: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore additional methods to identify cotesting are not necessary. See attached value sets. MEDICAL RECORD: Number of women who were screened for cervical cancer through either of the following criteria: -Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following: A note indicating the date when the cervical cytology was performed; and The result or finding. Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening. Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. NOTE: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test. -Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following: A note indicating the date when the hrHPV test was performed. Generic documentation of “HPV	'88150 CYTOPATH C/V MANUAL CPT4 '88152 CYTOPATH C/V AUTO REDO CPT4 '88153 CYTOPATH C/V REDO CPT4 '88154 CYTOPATH C/V SELECT CPT4 '88155 CYTOPATH C/V INDEX ADD-ON CPT4 '88164 CYTOPATH TBS C/V MANUAL CPT4 '88165 CYTOPATH TBS C/V REDO CPT4 '88166 CYTOPATH TBS C/V AUTO REDO CPT4 '88167 CYTOPATH TBS C/V SELECT CPT4 '88174 CYTOPATH C/V AUTO IN FLUID CPT4 '88175 CYTOPATH C/V AUTO FLUID REDO CPT4 '9146 CELL BLK&PAP SMER SPEC FE GNT TRACT ICD9P 'G0101 CERV/VAG CANCR SCR;PELV&CLN BRST EX HCPCS 'G0123 SCR CERV/VAG THIN LAY W/PHYS SUP HCPCS 'G0124 SCR CERV/VAG THIN LAY PHYS INTERP HCPCS 'G0141 SCR CERV/VAG MNL RSCR PHYS INTERP HCPCS 'G0143 SCR CERV/VAG MNL SCR/RSCR UND PHYS HCPCS 'G0144 SCR CERV/VAG SCR AUTO UND PHYS HCPCS 'G0145 SCR CERV/VAG AUTO&MNL RSCR PHYS HCPCS 'G0147 SCR SMEARS CERV/VAG AUTO UND PHYS HCPCS 'G0148 SCR SMEARS CERV/VAG MNL RESCR HCPCS 'P3000 SCR PAP SMER UP TO 3 TECH W/MD SUPV HCPCS 'P3001 SCR PAP SMER UP TO 3 RQR INTEPR MD HCPCS 'Q0091 SCR PAP SMER; OBTAIN PREP&CONVY-LAB HCPCS 'V7232 ENCOUNTR PAP CONFRM NL SMER FLW ABN ICD9 'V762 SCREENING MALIGNANT NEOPLASM CERVIX ICD9

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
	test" can be counted as evidence of hrHPV test; and The results or findings. Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. NOTE: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.	
Denominator Statement	Women 24-64 years of age as of the end of the measurement year.	Women who are 12-65 years of age who have a diagnosis of cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS diagnosed prior to the measurement year, and who still have a cervix (excludes women with a hysterectomy and no residual cervix).
Denominator Details	Use administrative data to identify all women 24-64 years of age as of the end of the measurement year.	- Age >12 and <65 years old as of the end of the measurement year - AND female - AND at least 1 claim prior to the measurement year for 1 or more of the following diagnoses: - cervical dysplasia (CIN 2), or - cervical carcinoma in-situ (CIN 3), or - HIV/AIDS, or - DES exposure in Utero, or - Transplant, or - Transplant Status - And eligible for service benefits for 2 years preceding the end of the measurement year Codes with descriptors: "CERVICAL CIS" '2331 CARCINOMA IN SITU OF CERVIX UTERI ICD9 "CERVICAL DYSPLASIA" '62210 DYSPLASIA OF CERVIX UNSPECIFIED ICD9 '62211 MILD DYSPLASIA OF CERVIX ICD9 '62212 MODERATE DYSPLASIA OF CERVIX ICD9 "DES EXPOSURE IN UTERO" '76076 NOX INFLU FETUS/NB PLACNTA/BRST DES ICD9 "HIV AIDS" '042 HUMAN IMMUNODEFICIENCY VIRUS [HIV] ICD9 '07953 HIV TYPE 2 IN CCE & UNS SITE ICD9 'V08 ASYMPTOMATIC HIV INFECTION STATUS ICD9 "TRANSPLANT"

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
		'00580 ANESTH HEART/LUNG TRANSPLNT CPT4 '00796 ANESTH FOR LIVER TRANSPLANT CPT4 '00868 ANESTH KIDNEY TRANSPLANT CPT4 '32851 LUNG TRANSPLANT SINGLE CPT4 '32852 LUNG TRANSPLANT WITH BYPASS CPT4 '32853 LUNG TRANSPLANT DOUBLE CPT4 '32854 LUNG TRANSPLANT WITH BYPASS CPT4 '335 LUNG TRANSPLANT ICD9P '3350 LUNG TRANSPLANTATION NOS ICD9P '3351 UNILATERAL LUNG TRANSPLANTATION ICD9P '3352 BILATERAL LUNG TRANSPLANTATION ICD9P '336 COMBINED HEART-LUNG TRANSPLANTATION ICD9P '33935 TRANSPLANTATION HEART/LUNG CPT4 '33945 TRANSPLANTATION OF HEART CPT4 '3751 HEART TRANSPLANTATION ICD9P '38240 BONE MARROW/STEM TRANSPLANT CPT4 '38241 BONE MARROW/STEM CELL TRANSPL; AUTO CPT4 '38242 BN MARROW/BLD STEM CELL TPLNT; ALLO CPT4 '410 BONE MARROW TRANSPLANT ICD9P '4100 BONE MARROW TRANSPLANT NOS ICD9P '4101 AUTOL BN MARROW TPLNT W/O PURGING ICD9P '4102 ALLOGENEIC MARROW TRANSPL-PURGE ICD9P '4103 ALLOGENEIC BONE MARROW TRANSPL ICD9P '4104 AUTO HEMAT ST CELL TRNSPLT W/O PURG ICD9P '4105 ALLO HEMAT ST CELL TRNSPLT W/O PURG ICD9P '4106 CORD BLOOD STEM CELL TRANSPLANT ICD9P '4107 AUTO HEMAT ST CELL TRNSPLT W PURG ICD9P '4108 ALLO HEMAT STEM CELL TRNSPLT W/PURG ICD9P '4109 AUTOL BN MARROW TPLNT W/PURGING ICD9P '47135 LIVER ALLOTRANSPL; ORTHOTOP-PRT/ALL CPT4

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
		'47136 LIVER ALLOTRANSPL; HETEROTOPIC CPT4 '47140 PARTIAL REMOVAL DONOR LIVER CPT4 '48160 PANCREATECT W/TPLNT PANC/ISLET CELL CPT4 '48554 TRANSPLANTATION PANCREATIC ALLOGFT CPT4 '50360 RENAL ALLOTRANSPL;W/O DONR NEPHRECT CPT4 '50365 RENAL ALLOTRANSPL; W/RECIP NEPHRECT CPT4 '505 LIVER TRANSPLANT ICD9P '5051 AUXILIARY LIVER TRANSPLANT ICD9P '5059 OTHER TRANSPLANT OF LIVER ICD9P '528 TRANSPLANT OF PANCREAS ICD9P '5280 PANCREATIC TRANSPLANT NOS ICD9P '5281 REIMPLANTATION OF PANCREATIC TISSUE ICD9P '5282 HOMOTRANSPLANT OF PANCREAS ICD9P '5283 HETEROTRANSPLANT OF PANCREAS ICD9P '5284 AUTOTPLNT CELLS ISLETS LANGERHANS ICD9P '5285 ALLOTPLNT CELLS ISLETS LANGERHANS ICD9P '5286 TPLNT CELLS ISLETS LANGERHANS NOS ICD9P '5569 OTHER KIDNEY TRANSPLANTATION ICD9P "TRANSPLANT STATUS" '1992 MALIG NEOPLSM ASSOC TRANSPLNT ORGAN ICD9 '9968 COMPLICATIONS OF TRANSPLANTED ORGAN ICD9 '99680 COMPS TPLNT ORGAN UNSPEC SITE ICD9 '99681 COMPLICATIONS TRANSPLANTED KIDNEY ICD9 '99682 COMPLICATIONS OF TRANSPLANTED LIVER ICD9 '99683 COMPLICATIONS OF TRANSPLANTED HEART ICD9 '99684 COMPLICATIONS OF TRANSPLANTED LUNG ICD9 '99685 COMPS BONE MARROW TRANSPLANT ICD9 '99686 COMPLICATIONS TRANSPLANTED PANCREAS ICD9

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
		'99687 COMPS TRANSPLANTED ORGAN INTESTINE ICD9 '99689 COMPS OTH TRANSPLANTED ORGAN ICD9 'V42 ORGAN OR TISSUE REPLACED TRANSPLANT ICD9 'V420 KIDNEY REPLACED BY TRANSPLANT ICD9 'V421 HEART REPLACED BY TRANSPLANT ICD9 'V426 LUNG REPLACED BY TRANSPLANT ICD9 'V427 LIVER REPLACED BY TRANSPLANT ICD9 'V428 OTH SPEC ORGN/TISS REPLCD TPLNT ICD9 'V4281 BONE MARROW REPLACED BY TRANSPLANT ICD9 'V4282 PERIPH STEM CELLS REPLCD TRANSPLANT ICD9 'V4283 PANCREAS REPLACED BY TRANSPLANT ICD9 'V4284 ORGN/TISS REPLCD TRANSPLANT INTEST ICD9 'V4289 OTH ORGAN/TISSUE REPLCD TRANSPLANT ICD9 'V429 UNSPEC ORGN/TISS REPLCD TRANSPLANT ICD9
Exclusions	This measure excludes women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.	No claims for cervical cancer screening exclusions, based on NCQA/HEDIS technical specifications: Women who had a hysterectomy with no residual cervix.
Exclusion Details	ADMINISTRATIVE: Exclude women who had evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set, Hysterectomy with No Residual Cervix Value Set) any time during their medical history through the end of the measurement year. See attached value sets. MEDICAL RECORD: Exclude women where there is documentation in the medical record of “complete,” “total” or “radical” abdominal or vaginal hysterectomy any time during their medical history through the end of the measurement year. The following also meet criteria: -Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy.”	"HYSTERECTOMY_HEDIS_D" '6185 PROLAPSE VAGINAL VAULT AFTER HYST ICD9 'V6701 FOLLOW SURG F/U VAGINAL PAP SMEAR ICD9 'V7647 SPECIAL SCR MALIG NEOPLSM VAGINA ICD9

	0032: Cervical Cancer Screening	0579: Annual cervical cancer screening or follow up in high risk women
	-Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening. Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.	
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification N/A
Stratification	N/A	The measure specifications do not require the results to be stratified.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population: identify women 24-64 years of age as of the end of the measurement year. Step 2: Exclude women who had evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year. Step 3: Determine the numerator: identify the number of women who were screened for cervical cancer following the instructions in the numerator details listed in Section S.5. Step 4: Divide the numerator from Step 3 by the denominator from Step 2 to determine the rate.	Please note previous answers. URL
Submission items	5.1 Identified measures: 0579 : Annual cervical cancer screening or follow-up in high-risk women 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The numerator for both measures focuses on women who had cervical cancer screening during the year, but #0579 focuses on a denominator of high-risk patients and is used in a surveillance strategy. The NCQA measure is intended to measure cervical cancer screening in the general population. Exclusions are aligned across these measures. 5b.1 If competing, why superior or rationale for additive value: NA	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #0509 and NQF #2372

	0509: Diagnostic Imaging: Reminder System for Screening Mammograms	2372: Breast Cancer Screening
Steward	American College of Radiology	National Committee for Quality Assurance
Description	Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer
Type	Structure	Process
Data Source	Claims, Registry Data We're using data submitted to CMS through claims and registries for the Merit-based Incentives Payment Program. No data collection instrument provided No data dictionary	Claims, Electronic Health Data 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. No data collection instrument provided Attachment 2372_Breast_Cancer_Screening_Value_Sets-636594894640541618.xlsx
Level	Clinician : Individual	Health Plan, Integrated Delivery System
Setting	Inpatient/Hospital, Outpatient Services	Outpatient Services
Numerator Statement	Patients whose information is entered into a reminder system with a target due date for the next mammogram	Women who received a mammogram to screen for breast cancer.
Numerator Details	Numerator Note: The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier, patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram. Use of the reminder system is not required to be documented within the final report to meet performance for this measure. Performance Met: Patient information entered into a reminder system with a target due date for the next mammogram (7025F) Performance Not Met: Patient Information not entered into a reminder system, reason not otherwise specified (7025F with 8P)	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

	0509: Diagnostic Imaging: Reminder System for Screening Mammograms	2372: Breast Cancer Screening
		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.
Denominator Statement	All patients undergoing a screening mammogram	Women 50-74 years of age.
Denominator Details	Denominator Criteria (Eligible Cases): All patients, regardless of age AND Diagnosis for mammogram screening (ICD-10-CM): Z12.31 Diagnosis for mammogram screening (ICD-9-CM)[for use 1/1/2015-9/30/2015]: V76.11, V76.12 AND Patient procedure during the performance period (CPT or HCPCS): 77067	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.
Exclusions	Documentation of medical reason(s) for not entering patient information into a reminder system [(eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s)]	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.
Exclusion Details	Documentation of medical reason(s) for not entering patient information into a reminder system (e.g., further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s) (7025F with 1P)	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

	0509: Diagnostic Imaging: Reminder System for Screening Mammograms	2372: Breast Cancer Screening
		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.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, sex, and payer.	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure.	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.
Submission items	5.1 Identified measures: 2372 : Breast Cancer Screening	5.1 Identified measures: 0508 : Diagnostic Imaging: Inappropriate Use of “Probably Benign”

	0509: Diagnostic Imaging: Reminder System for Screening Mammograms	2372: Breast Cancer Screening
	5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are no competing measures (conceptually both the same measure focus and same target population).	Assessment Category in Screening Mammograms 0509 : Diagnostic Imaging: Reminder System for Screening Mammograms 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 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.1 If competing, why superior or rationale for additive value: N/A

Appendix E: Related and Competing Measures

Comparison of NQF #0032 and NQF #0579

0032: Cervical Cancer Screening

0579: Annual cervical cancer screening or follow-up in high-risk women

Steward

0032: Cervical Cancer Screening

National Committee for Quality Assurance

0579: Annual cervical cancer screening or follow-up in high-risk women

Resolution Health, Inc.

Description

0032: Cervical Cancer Screening

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

-Women 21–64 years of age who had cervical cytology performed within the last 3 years.

-Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.

-Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

0579: Annual cervical cancer screening or follow-up in high-risk women

This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year.

Type

0032: Cervical Cancer Screening

Process

0579: Annual cervical cancer screening or follow-up in high-risk women

Process

Data Source

0032: Cervical Cancer Screening

Claims, Electronic Health Data, Paper Medical Records This measure is based on administrative claims and medical record documentation 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.

No data collection instrument provided Attachment 0032_CCS_Spring_2020_Value_Sets.xlsx

0579: Annual cervical cancer screening or follow-up in high-risk women

Claims (Only), Pharmacy Collection Instrument - administrative claims.

URL Attachment 0579- 2a1.30. Data Dictionary or Code Table.pdf

Level

0032: Cervical Cancer Screening

Health Plan

0579: Annual cervical cancer screening or follow-up in high-risk women

Population : Community, County or City, Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System

Setting

0032: Cervical Cancer Screening

Outpatient Services

0579: Annual cervical cancer screening or follow-up in high-risk women

Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office

Numerator Statement

0032: Cervical Cancer Screening

The number of women who were screened for cervical cancer.

0579: Annual cervical cancer screening or follow-up in high-risk women

Patients in the denominator who had a cervical CA screen during the measurement year

Numerator Details

0032: Cervical Cancer Screening

ADMINISTRATIVE:

Number of women who were screened for cervical cancer through either of the following criteria:

-Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.

-Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test.

NOTE: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore additional methods to identify cotesting are not necessary.

See attached value sets.

MEDICAL RECORD:

Number of women who were screened for cervical cancer through either of the following criteria:

-Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:

A note indicating the date when the cervical cytology was performed; and

The result or finding.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

NOTE: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

-Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:

A note indicating the date when the hrHPV test was performed. Generic documentation of “HPV test” can be counted as evidence of hrHPV test; and

The results or findings.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

NOTE: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.

0579: Annual cervical cancer screening or follow-up in high-risk women

>=1 procedure claim for a cervical cancer screen during the measurement year.

Codes with descriptors:

'0923 Other Diagnostic Services HSREV

'88141 CYTOPATH C/V INTERPRET CPT4

'88142 CYTOPATH C/V THIN LAYER CPT4

'88143 CYTOPATH CERV/VAG; W/MNL SCR-RESCR CPT4
'88147 CYTOPATH C/V AUTOMATED CPT4
'88148 CYTOPATH C/V AUTO RESCREEN CPT4
'88150 CYTOPATH C/V MANUAL CPT4
'88152 CYTOPATH C/V AUTO REDO CPT4
'88153 CYTOPATH C/V REDO CPT4
'88154 CYTOPATH C/V SELECT CPT4
'88155 CYTOPATH C/V INDEX ADD-ON CPT4
'88164 CYTOPATH TBS C/V MANUAL CPT4
'88165 CYTOPATH TBS C/V REDO CPT4
'88166 CYTOPATH TBS C/V AUTO REDO CPT4
'88167 CYTOPATH TBS C/V SELECT CPT4
'88174 CYTOPATH C/V AUTO IN FLUID CPT4
'88175 CYTOPATH C/V AUTO FLUID REDO CPT4
'9146 CELL BLK&PAP SMER SPEC FE GNT TRACT ICD9P
'G0101 CERV/VAG CANCR SCR;PELV&CLN BRST EX HCPCS
'G0123 SCR CERV/VAG THIN LAY W/PHYS SUP HCPCS
'G0124 SCR CERV/VAG THIN LAY PHYS INTERP HCPCS
'G0141 SCR CERV/VAG MNL RSCR PHYS INTERP HCPCS
'G0143 SCR CERV/VAG MNL SCR/RSCR UND PHYS HCPCS
'G0144 SCR CERV/VAG SCR AUTO UND PHYS HCPCS
'G0145 SCR CERV/VAG AUTO&MNL RSCR PHYS HCPCS
'G0147 SCR SMEARS CERV/VAG AUTO UND PHYS HCPCS
'G0148 SCR SMEARS CERV/VAG MNL RESCR HCPCS
'P3000 SCR PAP SMER UP TO 3 TECH W/MD SUPV HCPCS
'P3001 SCR PAP SMER UP TO 3 RQR INTEPR MD HCPCS
'Q0091 SCR PAP SMER; OBTAIN PREP&CONVY-LAB HCPCS
'V7232 ENCOUNTR PAP CONFRM NL SMER FLW ABN ICD9
'V762 SCREENING MALIGNANT NEOPLASM CERVIX ICD9

Denominator Statement

0032: Cervical Cancer Screening

Women 24-64 years of age as of the end of the measurement year.

0579: Annual cervical cancer screening or follow-up in high-risk women

Women who are 12-65 years of age who have a diagnosis of cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS diagnosed prior to the measurement year, and who still have a cervix (excludes women with a hysterectomy and no residual cervix).

Denominator Details

0032: Cervical Cancer Screening

Use administrative data to identify all women 24-64 years of age as of the end of the measurement year.

0579: Annual cervical cancer screening or follow-up in high-risk women

- Age >12 and <65 years old as of the end of the measurement year
- AND female
- AND at least 1 claim prior to the measurement year for 1 or more of the following diagnoses:
 - cervical dysplasia (CIN 2), or
 - cervical carcinoma in-situ (CIN 3), or
 - HIV/AIDS, or
 - DES exposure in Utero, or
 - Transplant, or
 - Transplant Status
- And eligible for service benefits for 2 years preceding the end of the measurement year

Codes with descriptors:

"CERVICAL CIS"

'2331 CARCINOMA IN SITU OF CERVIX UTERI ICD9

"CERVICAL DYSPLASIA"

'62210 DYSPLASIA OF CERVIX UNSPECIFIED ICD9

'62211 MILD DYSPLASIA OF CERVIX ICD9

'62212 MODERATE DYSPLASIA OF CERVIX ICD9

"DES EXPOSURE IN UTERO"

'76076 NOX INFLU FETUS/NB PLACNTA/BRST DES ICD9
"HIV AIDS"
'042 HUMAN IMMUNODEFICIENCY VIRUS [HIV] ICD9
'07953 HIV TYPE 2 IN CCE & UNS SITE ICD9
'V08 ASYMPTOMATIC HIV INFECTION STATUS ICD9
"TRANSPLANT"
'00580 ANESTH HEART/LUNG TRANSPLNT CPT4
'00796 ANESTH FOR LIVER TRANSPLANT CPT4
'00868 ANESTH KIDNEY TRANSPLANT CPT4
'32851 LUNG TRANSPLANT SINGLE CPT4
'32852 LUNG TRANSPLANT WITH BYPASS CPT4
'32853 LUNG TRANSPLANT DOUBLE CPT4
'32854 LUNG TRANSPLANT WITH BYPASS CPT4
'335 LUNG TRANSPLANT ICD9P
'3350 LUNG TRANSPLANTATION NOS ICD9P
'3351 UNILATERAL LUNG TRANSPLANTATION ICD9P
'3352 BILATERAL LUNG TRANSPLANTATION ICD9P
'336 COMBINED HEART-LUNG TRANSPLANTATION ICD9P
'33935 TRANSPLANTATION HEART/LUNG CPT4
'33945 TRANSPLANTATION OF HEART CPT4
'3751 HEART TRANSPLANTATION ICD9P
'38240 BONE MARROW/STEM TRANSPLANT CPT4
'38241 BONE MARROW/STEM CELL TRANSPL; AUTO CPT4
'38242 BN MARROW/BLD STEM CELL TPLNT; ALLO CPT4
'410 BONE MARROW TRANSPLANT ICD9P
'4100 BONE MARROW TRANSPLANT NOS ICD9P
'4101 AUTOL BN MARROW TPLNT W/O PURGING ICD9P
'4102 ALLOGENEIC MARROW TRANSPL-PURGE ICD9P
'4103 ALLOGENEIC BONE MARROW TRANSPL ICD9P
'4104 AUTO HEMAT ST CELL TRNSPLT W/O PURG ICD9P

'4105 ALLO HEMAT ST CELL TRNSPLT W/O PURG ICD9P
'4106 CORD BLOOD STEM CELL TRANSPLANT ICD9P
'4107 AUTO HEMAT ST CELL TRNSPLT W PURG ICD9P
'4108 ALLO HEMAT STEM CELL TRNSPLT W/PURG ICD9P
'4109 AUTOL BN MARROW TPLNT W/PURGING ICD9P
'47135 LIVER ALLOTRANSPL; ORTHOTOP-PRT/ALL CPT4
'47136 LIVER ALLOTRANSPL; HETEROTOPIC CPT4
'47140 PARTIAL REMOVAL DONOR LIVER CPT4
'48160 PANCREATECT W/TPLNT PANC/ISLET CELL CPT4
'48554 TRANSPLANTATION PANCREATIC ALLOGFT CPT4
'50360 RENAL ALLOTRANSPL;W/O DONR NEPHRECT CPT4
'50365 RENAL ALLOTRANSPL; W/RECIP NEPHRECT CPT4
'505 LIVER TRANSPLANT ICD9P
'5051 AUXILIARY LIVER TRANSPLANT ICD9P
'5059 OTHER TRANSPLANT OF LIVER ICD9P
'528 TRANSPLANT OF PANCREAS ICD9P
'5280 PANCREATIC TRANSPLANT NOS ICD9P
'5281 REIMPLANTATION OF PANCREATIC TISSUE ICD9P
'5282 HOMOTRANSPLANT OF PANCREAS ICD9P
'5283 HETEROTRANSPLANT OF PANCREAS ICD9P
'5284 AUTOTPLNT CELLS ISLETS LANGERHANS ICD9P
'5285 ALLOTPLNT CELLS ISLETS LANGERHANS ICD9P
'5286 TPLNT CELLS ISLETS LANGERHANS NOS ICD9P
'5569 OTHER KIDNEY TRANSPLANTATION ICD9P
"TRANSPLANT STATUS"
'1992 MALIG NEOPLSM ASSOC TRANSPLNT ORGAN ICD9
'9968 COMPLICATIONS OF TRANSPLANTED ORGAN ICD9
'99680 COMPS TPLNT ORGAN UNSPEC SITE ICD9
'99681 COMPLICATIONS TRANSPLANTED KIDNEY ICD9
'99682 COMPLICATIONS OF TRANSPLANTED LIVER ICD9

'99683 COMPLICATIONS OF TRANSPLANTED HEART ICD9

'99684 COMPLICATIONS OF TRANSPLANTED LUNG ICD9

'99685 COMPS BONE MARROW TRANSPLANT ICD9

'99686 COMPLICATIONS TRANSPLANTED PANCREAS ICD9

'99687 COMPS TRANSPLANTED ORGAN INTESTINE ICD9

'99689 COMPS OTH TRANSPLANTED ORGAN ICD9

'V42 ORGAN OR TISSUE REPLACED TRANSPLANT ICD9

'V420 KIDNEY REPLACED BY TRANSPLANT ICD9

'V421 HEART REPLACED BY TRANSPLANT ICD9

'V426 LUNG REPLACED BY TRANSPLANT ICD9

'V427 LIVER REPLACED BY TRANSPLANT ICD9

'V428 OTH SPEC ORGN/TISS REPLCD TPLNT ICD9

'V4281 BONE MARROW REPLACED BY TRANSPLANT ICD9

'V4282 PERIPH STEM CELLS REPLCD TRANSPLANT ICD9

'V4283 PANCREAS REPLACED BY TRANSPLANT ICD9

'V4284 ORGN/TISS REPLCD TRANSPLANT INTEST ICD9

'V4289 OTH ORGAN/TISSUE REPLCD TRANSPLANT ICD9

'V429 UNSPEC ORGN/TISS REPLCD TRANSPLANT ICD9

Exclusions

0032: Cervical Cancer Screening

This measure excludes women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.

0579: Annual cervical cancer screening or follow-up in high-risk women

No claims for cervical cancer screening exclusions, based on NCQA/HEDIS technical specifications: Women who had a hysterectomy with no residual cervix.

Exclusion Details

0032: Cervical Cancer Screening

ADMINISTRATIVE:

Exclude women who had evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set, Hysterectomy with No Residual Cervix Value Set) any time during their medical history through the end of the measurement year.

See attached value sets.

MEDICAL RECORD:

Exclude women where there is documentation in the medical record of “complete,” “total” or “radical” abdominal or vaginal hysterectomy any time during their medical history through the end of the measurement year. The following also meet criteria:

-Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy.”

-Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening. Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

0579: Annual cervical cancer screening or follow-up in high-risk women

"HYSTERECTOMY_HEDIS_D"

'6185 PROLAPSE VAGINAL VAULT AFTER HYST ICD9

'V6701 FOLLOW SURG F/U VAGINAL PAP SMEAR ICD9

'V7647 SPECIAL SCR MALIG NEOPLSM VAGINA ICD9

Risk Adjustment

0032: Cervical Cancer Screening

No risk adjustment or risk stratification

0579: Annual cervical cancer screening or follow-up in high-risk women

No risk adjustment or risk stratification

N/A

Stratification

0032: Cervical Cancer Screening

N/A

0579: Annual cervical cancer screening or follow-up in high-risk women

The measure specifications do not require the results to be stratified.

Type Score

0032: Cervical Cancer Screening

Rate/proportion better quality = higher score

0579: Annual cervical cancer screening or follow-up in high-risk women

Rate/proportion better quality = higher score

Algorithm

0032: Cervical Cancer Screening

Step 1: Determine the eligible population: identify women 24-64 years of age as of the end of the measurement year.

Step 2: Exclude women who had evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.

Step 3: Determine the numerator: identify the number of women who were screened for cervical cancer following the instructions in the numerator details listed in Section S.5.

Step 4: Divide the numerator from Step 3 by the denominator from Step 2 to determine the rate.

0579: Annual cervical cancer screening or follow-up in high-risk women

Please note previous answers. URL

Submission items

0032: Cervical Cancer Screening

5.1 Identified measures: 0579 : Annual cervical cancer screening or follow-up in high-risk women

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The numerator for both measures focuses on women who had cervical cancer screening during the year, but #0579 focuses on a denominator of high-risk patients and is used in a surveillance strategy. The NCQA measure is intended to measure cervical cancer screening in the general population. Exclusions are aligned across these measures.

5b.1 If competing, why superior or rationale for additive value: NA

0579: Annual cervical cancer screening or follow-up in high-risk women

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

Comparison of NQF #0509 and NQF #2372

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

2372: Breast Cancer Screening

Steward

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

American College of Radiology

2372: Breast Cancer Screening

National Committee for Quality Assurance

Description

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

2372: Breast Cancer Screening

Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer

Type

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Structure

2372: Breast Cancer Screening

Process

Data Source

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Claims, Registry Data We're using data submitted to CMS through claims and registries for the Merit-based Incentives Payment Program.

No data collection instrument provided No data dictionary

2372: Breast Cancer Screening

Claims, Electronic Health Data 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.

No data collection instrument provided Attachment 2372_Breast_Cancer_Screening_Value_Sets-636594894640541618.xlsx

Level

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Clinician : Individual

2372: Breast Cancer Screening

Health Plan, Integrated Delivery System

Setting

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Inpatient/Hospital, Outpatient Services

2372: Breast Cancer Screening

Outpatient Services

Numerator Statement

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Patients whose information is entered into a reminder system with a target due date for the next mammogram

2372: Breast Cancer Screening

Women who received a mammogram to screen for breast cancer.

Numerator Details

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Numerator Note:

The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier, patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram. Use of the reminder system is not required to be documented within the final report to meet performance for this measure.

Performance Met: Patient information entered into a reminder system with a target due date for the next mammogram (7025F)

Performance Not Met: Patient Information not entered into a reminder system, reason not otherwise specified (7025F with 8P)

2372: Breast Cancer Screening

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.

Denominator Statement

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

All patients undergoing a screening mammogram

2372: Breast Cancer Screening

Women 50-74 years of age.

Denominator Details

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Denominator Criteria (Eligible Cases):

All patients, regardless of age

AND

Diagnosis for mammogram screening (ICD-10-CM): Z12.31

Diagnosis for mammogram screening (ICD-9-CM)[for use 1/1/2015-9/30/2015]: V76.11, V76.12

AND

Patient procedure during the performance period (CPT or HCPCS): 77067

2372: Breast Cancer Screening

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.

Exclusions

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Documentation of medical reason(s) for not entering patient information into a reminder system [(eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s)]

2372: Breast Cancer Screening

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.

Exclusion Details

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Documentation of medical reason(s) for not entering patient information into a reminder system (e.g., further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s) (7025F with 1P)

2372: Breast Cancer Screening

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.

Risk Adjustment

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

No risk adjustment or risk stratification

2372: Breast Cancer Screening

No risk adjustment or risk stratification

Stratification

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

We encourage the results of this measure to be stratified by race, ethnicity, sex, and payer.

2372: Breast Cancer Screening

N/A

Type Score

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

Rate/proportion better quality = higher score

2372: Breast Cancer Screening

Rate/proportion better quality = higher score

Algorithm

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

To calculate performance rates:

1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).

2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

2372: Breast Cancer Screening

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.

Submission items

0509: Diagnostic Imaging: Reminder System for Screening Mammograms

5.1 Identified measures: 2372 : Breast Cancer Screening

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: There are no competing measures (conceptually both the same measure focus and same target population).

2372: Breast Cancer Screening

5.1 Identified measures: 0508 : Diagnostic Imaging: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms

0509 : Diagnostic Imaging: Reminder System for Screening Mammograms

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: 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.1 If competing, why superior or rationale for additive value: N/A

Appendix F: Pre-Evaluation Comments

As of June 19, 2020, no NQF member comments were received during the pre-commenting period.

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