



Measure Information

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

Brief Measure Information

NQF #: 0032

Corresponding Measures:

De.2. Measure Title: Cervical Cancer Screening

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: 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.

1b.1. Developer Rationale: This measure assesses appropriate cervical cancer screening by seeking to ensure that women 21–64 years of age are screened for cervical cancer using the appropriate criteria for their age. Each year, approximately 12,000 women are diagnosed with cervical cancer in the U.S. (U.S. Cancer Statistics Working Group, 2015). Research suggests that cervical cancer is preventable with regular screening and follow-up and is curable if found and treated early. Adherence to this measure could lead to early treatment in affected women, which is associated with long survival and improved quality of life (CDC 2015).

Centers for Disease Control and Prevention (CDC). 2015. "Gynecologic Cancers: Cervical Cancer." <http://www.cdc.gov/cancer/cervical/> (May 20, 2016).

U.S. Cancer Statistics Working Group. 2015. "United States Cancer Statistics: 1999–2012 Incidence and Mortality Web-based Report." Atlanta: U.S. Department of Health and Human Services. www.cdc.gov/uscs (May 20, 2016)

S.4. Numerator Statement: The number of women who were screened for cervical cancer.

S.6. Denominator Statement: Women 24–64 years of age as of the end of the measurement year.

S.8. Denominator 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.

De.1. Measure Type: Process

S.17. Data Source: Claims, Electronic Health Data, Paper Medical Records

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Nov 20, 2020

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

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

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

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

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-

than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[Evidence_Form_CCS.docx](#)

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

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

Yes

1b. Performance Gap

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

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

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

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

This measure assesses appropriate cervical cancer screening by seeking to ensure that women 21-64 years of age are screened for cervical cancer using the appropriate criteria for their age. Each year, approximately 12,000 women are diagnosed with cervical cancer in the U.S. (U.S. Cancer Statistics Working Group, 2015). Research suggests that cervical cancer is preventable with regular screening and follow-up and is curable if found and treated early. Adherence to this measure could lead to early treatment in affected women, which is associated with long survival and improved quality of life (CDC 2015).

Centers for Disease Control and Prevention (CDC). 2015. "Gynecologic Cancers: Cervical Cancer." <http://www.cdc.gov/cancer/cervical/> (May 20, 2016).

U.S. Cancer Statistics Working Group. 2015. "United States Cancer Statistics: 1999–2012 Incidence and Mortality Web-based Report." Atlanta: U.S. Department of Health and Human Services. www.cdc.gov/uscs (May 20, 2016)

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

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data are summarized at the health plan level by mean, standard deviation, and performance at the 10th, 25th, 50th, 75th and 90th percentile. We also calculated the interquartile range (IQR), which can be interpreted as the difference between the 25th and 75th percentile. Data are stratified by year and product line (i.e. commercial and Medicaid). The following data demonstrate room for improvement and variation in the rate of cervical cancer screening across health plans.

Commercial Rate

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2019	74.3%	6.7%	66.1%	70.8%	74.5%	78.5%	82.1%	7.7
2018	73.8%	7.3%	65.6%	70.4%	74.4%	78.0%	81.8%	7.6
2017	73.6%	7.2%	65.5%	69.9%	74.5%	77.9%	81.4%	7.9

Medicaid Rate

YEAR	MEAN	ST DEV	10TH	25TH	50TH	75TH	90TH	Interquartile Range
2019	59.3%	11.6%	45.9%	55.2%	60.5%	66.2%	72.0%	10.9
2018	59.4%	10.1%	47.2%	54.3%	60.1%	66.0%	70.6%	11.7
2017	58.0%	11.4%	44.7%	51.9%	58.4%	65.7%	70.8%	13.8

These rates are extracted from HEDIS data collection and reflect the most recent years of measurement for this measure. For HEDIS 2019 (calendar year 2018), HEDIS measures covered 116 million commercial health plan members and 54 million Medicaid enrollees. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data

collection and the mean eligible population for the measure across health plans.

Commercial

YEAR | N Plans | Mean Denominator Size

2019 | 402 | 20,108

2018 | 404 | 23,053

2017 | 418 | 14,237

Medicaid

YEAR | N Plans | Mean Denominator Size

2019 | 245 | 1,754

2018 | 262 | 936

2017 | 265 | 1,903

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

N/A

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

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. HEDIS includes two measures that can be used as tools for assessing race/ethnicity and language needs of a plan’s population: Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA’s Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities.

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

In 2012, eight million U.S. women reported they had not been screened in the last 5 years (CDC 2014). Among women aged 21 to 65 years who responded to the 2015 National Health Interview Survey (NHIS), the national average reported rate for cytology alone was 81% and for cotesting was 32%. African American women were most likely to have had cervical cancer screening within 3 years; 85% of African American women reported having a cytology test and 35% reported having cotesting (Watson et al. 2017). The rates for white women were slightly above the national average rates (cytology alone: 83%; cotesting: 33%) (Watson et al. 2017). Both Hispanic women and Asian women had rates below the national average performance, with Asian women reporting the lowest screening rates (cytology alone: 74%; cotesting: 21%) (Watson et al. 2017). Multiple studies have found that barriers include Hispanic ethnicity, patient fear of finding cancer, and language could be barriers to screening (Akinlotan et al. 2017).

Despite gains among African American women (Watson et al. 2017; Beavis et al. 2017), a recent meta-analysis covering research from 2000 to 2012 found there is still a racial disparity in cervical cancer mortality. The mortality rate for African American women was 5.7 per 100,000, compared to 4.7 per 100,000 for white women (Beavis et al. 2017). Disparities in mortality still exist due to inadequate follow-up after screening, differences in treatment, and, in part, the higher-than-average rate of adenocarcinoma in African American women (Galic et al. 2012; Wang et al. 2004). Adenocarcinoma is a rarer type of cervical cancer with malignant cells found in the inner part of the cervix (NCI 2018). Compared to squamous cell carcinoma, adenocarcinoma has a dramatically worse 5-year survival rate in stage II cervical cancer patients (Shimada et al. 2013), which may partially explain why African American women have a higher mortality rate.

Akinlotan M, Bolin JN, Helduser J, Ojinnaka C, Lichorad A, McClellan D. 2017. Cervical Cancer Screening Barriers and Risk Factor Knowledge Among Uninsured Women. J Community Health. 42(4): 770–778.

Beavis, A.L., Gravitt, P.E., Rositch, A.F. 2017. Hysterectomy-corrected cervical cancer mortality rates reveal a larger racial disparity in the United States. Cancer. 123(6):1044-50.

Centers for Disease Control and Prevention. 2014. “Cervical Cancer is Preventable.” Last modified November 5, 2014 <https://www.cdc.gov/vitalsigns/cervical-cancer/>

Galic, V., Herzog, T.J., Lewin, S.N., et al. 2012. Prognostic significance of adenocarcinoma histology in women with cervical cancer. Gynecol Oncol. 125(2):287-91.

National Cancer Institute. 2018. “NCI Dictionary of Cancer Terms - Adenocarcinoma.” (October 12, 2018) <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/adenocarcinoma>

Shimada, M., Nishimura, R., Nogawa, T., Hatae, M., Takehara, K., Yamada, H. ... Kigawa, J. 2013. Comparison of the outcome between cervical adenocarcinoma and squamous cell carcinoma patients with adjuvant radiotherapy following radical surgery: SSGS/TGCU Intergroup Surveillance. Molecular and Clinical Oncology, 1, 780-784. (October 12, 2018) doi.org/10.3892/mco.2013.112

Wang, S.S., Sherman, M.E., Hildesheim, A., Lacey, J.V., Jr, Devesa, S. 2004. Cervical adenocarcinoma and squamous cell carcinoma incidence trends among white women and black women in the United States for 1976-2000. Cancer. 100(5):1035-44.

Watson, M., Benard, V., King, J., Crawford, A., Saraiya, M. 2017. National assessment of HPV and Pap tests: Changes in cervical cancer screening, National Health Interview Survey. Prev Med. 100:243-247. (October 12, 2018) [doi: 10.1016/j.ypmed.2017.05.004](https://doi.org/10.1016/j.ypmed.2017.05.004).

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

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

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

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

N/A

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

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or

csv file in the suggested format preferred - if not, contact staff)

Attachment **Attachment:** 0032_CCS_Spring_2020_Value_Sets.xlsx

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

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

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

Not an instrument-based measure

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

Yes

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

Since the last endorsement date, the U.S. Preventive Services Task Force released updated guidelines on cervical cancer screening and added a new screening method. Accordingly, NCQA updated the measure to align with the latest guidelines by adding high-risk HPV (hrHPV) testing alone every five years as an acceptable screening method for women ages 30-65. Additionally, as part of NCQA's annual measure maintenance, we routinely make coding and other minor specification updates to ensure the measure remains up-to-date with current practice and based on feedback received from measure users.

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

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

The number of women who were screened for cervical cancer.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

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

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.

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

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

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

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

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

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

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.

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

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.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

N/A

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

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic *(Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*

Step 1: Determine the eligible population: identify women 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.

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

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

This measure can be reported using Administrative and/or Medical Record data. For organizations that choose to report the measure using Medical Record data, a sample size of 411 is used. A sample size of 411 is used because it allows for the 95% confidence interval around the rate, meaning that a 5% difference in plan performance is statistically significant. NCQA provides a Random Number table that organizations use to assist with sample selection.

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

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

N/A

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

If other, please describe in S.18.

Claims, Electronic Health Data, Paper Medical Records

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

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

This measure is based on administrative claims 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.

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

No data collection instrument provided

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

Health Plan

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

Outpatient Services

If other:

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

N/A

2. Validity – See attached Measure Testing Submission Form

[FINAL_Testing_Form_CCS.docx](#)

2.1 For maintenance of endorsement

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

Yes

2.2 For maintenance of endorsement

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

Yes

2.3 For maintenance of endorsement

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

No - This measure is not risk-adjusted

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

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

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed

to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

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

To allow for widespread reporting across health plans, this measure is collected through multiple data sources (administrative data, electronic clinical data, paper records, and registry). We anticipate as electronic health records become more widespread the reliance on paper record review will decrease.

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

Attachment:

3c. Data Collection Strategy

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

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

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

NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable comparisons between health plans.

?

The HEDIS Compliance Audit addresses the following functions:

1) Information practices and control procedures?

2) Sampling methods and procedures?

3) Data integrity?

4) Compliance with HEDIS specifications?

5) Analytic file production?

6) Reporting and documentation?

?

In addition to the HEDIS audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system, NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system informs both annual updates to the measures as well as routine re-evaluation of measures. These processes include updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence.

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

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting</p> <p>CMS Medicaid Adult Core Set https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html</p> <p>CMS Qualified Health Plan (QHP) Quality Rating System (QRS) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf</p> <p>NCQA Health Plan Rating/Report Card http://reportcard.ncqa.org/plan/external/plansearch.aspx</p> <p>CMS Medicaid Adult Core Set https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html</p> <p>CMS Qualified Health Plan (QHP) Quality Rating System (QRS) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS_and_QHP_Enrollee_Survey_Technical_Guidance.pdf</p> <p>NCQA Health Plan Rating/Report Card http://reportcard.ncqa.org/plan/external/plansearch.aspx</p> <p>Payment Program</p> <p>California Align. Measure. Perform. (AMP) Commercial HMO Program https://www.iha.org/our-work/accountability/value-based-p4p</p> <p>California Align. Measure. Perform. (AMP) Medi-Cal Managed Care Program https://www.iha.org/our-work/accountability/medi-cal</p> <p>CMS Medicare Advantage Plan Rating System (STARS) https://www.medicare.gov/find-a-plan/questions/home.aspx</p> <p>California Align. Measure. Perform. (AMP) Commercial HMO Program https://www.iha.org/our-work/accountability/value-based-p4p</p> <p>California Align. Measure. Perform. (AMP) Medi-Cal Managed Care Program https://www.iha.org/our-work/accountability/medi-cal</p> <p>CMS Medicare Advantage Plan Rating System (STARS) https://www.medicare.gov/find-a-plan/questions/home.aspx</p> <p>Regulatory and Accreditation Programs</p> <p>NCQA Health Plan Accreditation http://www.ncqa.org/tabid/123/Default.aspx</p> <p>NCQA Accountable Care Organization Accreditation http://www.ncqa.org/Programs/OtherPrograms/comeasuresPilotProject.aspx</p> <p>NCQA Health Plan Accreditation</p>

	http://www.ncqa.org/tabid/123/Default.aspx NCQA Accountable Care Organization Accreditation http://www.ncqa.org/Programs/OtherPrograms/comeasuresPilotProject.aspx Quality Improvement (external benchmarking to organizations) NCQA Quality Compass http://www.ncqa.org/tabid/177/Default.aspx NCQA Annual State of Health Care Quality http://www.ncqa.org/tabid/836/Default.aspx
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4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

CALIFORNIA ALIGN. MEASURE. PERFORM. (AMP) COMMERCIAL HMO PROGRAM: This measure is used in California's (AMP) Commercial HMO program. California's AMP programs focus on creating comprehensive benchmarks and a reliable assessment of performance for medical groups, independent practice association (IPAs), and accountable care organizations (ACOs) across health plans. The AMP Commercial HMO program (formerly known as Value Based Pay for Performance) is the cornerstone upon which all of IHA's performance measurement programs were built. Initiated in 2001, the program now includes participation from eleven health plans and about 200 California physician organizations caring for over 9 million Californians enrolled in commercial HMO and point of service products—representing 95% of commercial HMO enrollment in the state. AMP Commercial HMO has four key components: a common set of measures and benchmarks that spans clinical quality, patient experience, utilization, and cost of care measures; value-based health plan incentive payments to physician organizations; public reporting of Triple Aim performance results for physician organizations; and public recognition awards.

CALIFORNIA ALIGN. MEASURE. PERFORM. (AMP) MEDI-CAL MANAGED CARE PROGRAM: This measure is used in California's (AMP) Medi-Cal Managed Care program. California's AMP programs focus on creating comprehensive benchmarks and a reliable assessment of performance for medical groups, independent practice association (IPAs), and accountable care organizations (ACOs) across health plans. The AMP Medi-Cal Managed Care program is based on a common set of measures and benchmarks that spans clinical quality, patient experience, utilization, and cost of care measures. The program collects data and calculates performance results for medical groups, IPAs and FQHCs that provide care to Medi-Cal Managed Care enrollees. Health plans can use the results to make value-based incentive payments to their contracted providers.

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

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

NCQA HEALTH PLAN RATING/REPORT CARDS: This measure is used to calculate health plan rankings which are reported on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2019, a total of 515 commercial health plans and 188 Medicaid health plans across 50 states were included in the rankings.

NCQA STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2019, the report included results from calendar year 2018 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

NCQA HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of commercial and Medicaid health plans. In 2019, 336 commercial health plans covering 87 million lives and 77 Medicaid health plans covering 9.1 million lives were accredited. Health plans are scored based on performance compared to benchmarks.

NCQA ACCOUNTABLE CARE ORGANIZATION ACCREDITATION: This measure is used in NCQA's ACO Accreditation program, that helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. ACO standards and guidelines incorporate whole-person care coordination throughout the health care system.

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

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

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

NA

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

NA

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

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

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

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

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

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

Describe how feedback was obtained.

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

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

In general, health plans have not reported significant barriers to implementing this measure. Questions received through the Policy Clarification Support system have generally centered around minor clarification about the screening methods that satisfy the measure numerator. During a recent public comment session, a majority of comments from measured entities supported updates to the measure to align with the latest clinical recommendations.

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

This measure has been deemed a priority measure by NCQA and other entities such as the Centers for Medicare and Medicaid Services as illustrated by its use in the Medicare Advantage Health Plan Rating System and the Medicaid Adult Core Set program.

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

During the measure's last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure to include new screening methods recommended by the U.S. Preventive Services Task Force and other major clinical guideline organizations.

Improvement

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

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

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

Over the past three years, this measure has shown slight improvement (approximately 1% improvement over the past three years) across health plans (see section 1b.2 for summary of data from health plans). The greatest improvement in performance has been seen for Medicaid plans (avg. 1.3% improvement in the average rate and 2% improvement for plans at the 90th percentile). Additionally, in 2019 there was an 11 point difference between Medicaid plans in the 25th percentile and Medicaid plans in the 75th percentile, demonstrating additional room for improvement. These data are nationally representative.

4b2. Unintended Consequences

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

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

There were no identified unintended consequences for this measure during testing or since implementation.

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

There were no identified unexpected findings during testing or since implementation.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

Yes

<p>5.1a. List of related or competing measures (selected from NQF-endorsed measures) 0579 : Annual cervical cancer screening or follow-up in high-risk women</p> <p>5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.</p>
<p>5a. Harmonization of Related Measures The measure specifications are harmonized with related measures; OR The differences in specifications are justified</p> <p>5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications harmonized to the extent possible? No</p> <p>5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden. 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.</p>
<p>5b. Competing Measures The measure is superior to competing measures (e.g., is a more valid or efficient way to measure); OR Multiple measures are justified.</p> <p>5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.) NA</p>

<p>Appendix</p> <p>A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed. No appendix Attachment:</p>
<p>Contact Information</p> <p>Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728- Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance Co.4 Point of Contact: Brittany, Wade, wade@ncqa.org, 202-530-0463-</p>
<p>Additional Information</p> <p>Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. CERVICAL CANCER SCREENING MEASUREMENT ADVISORY PANEL Andrea Gelzer, MD, AmeriHealth Caritas Stephanie Glover, National Partnership for Women and Families</p>

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George Sawaya, MD, University of California San Francisco
Laurie Spoll, Aetna
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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 1994

Ad.3 Month and Year of most recent revision: 12, 2019

Ad.4 What is your frequency for review/update of this measure? Approximately every three years

Ad.5 When is the next scheduled review/update for this measure? 12, 2021

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