March 20, 2013

National Committee for Quality Assurance
1100 13th St., NW Suite 1000
Washington, D.C. 20005

Re: Comments on Proposed Changes to HEDIS 2014: Breast Cancer Screening Measure

Performance Measurement Committee:

The American College of Radiology (ACR) and the Society for Breast Imaging (SBI) appreciate the opportunity to comment on the proposed changes to the HEDIS 2014 Breast Cancer Screening measure. The American College of Radiology (ACR) represents more than 32,000 radiologists, radiation oncologists, medical physicists, interventional radiologists and nuclear medicine physicians. The Society of Breast Imaging is a non-profit professional organization of radiologists, medical physicists and technologists interested in breast imaging. The society has more than two thousand professional members throughout the world.

NCQA has proposed the following changes to the current HEDIS Breast Cancer Screening measure:

- Age to screen. Change the denominator age range to 50-74, from 40-69.
- Numerator time frame. Increase the timeframe for documentation of a mammogram from 24 months to 30 months.
- Numerator language. Modify numerator from “mammograms” to “a” mammogram.

The ACR and SBI offer the following comments:

**Age to screen**

The ACR and SBI feel strongly that the age to begin routine screening mammography should remain at the age of 40. Despite the 2009 USPSTF change in recommendation regarding the age to begin routine mammography screening, important major American medical organizations with expertise in breast cancer detection and care, including the American Congress of Obstetricians and Gynecologists (ACOG), American Cancer Society, American Society of Breast Surgeons,
National Comprehensive Cancer Network, American College of Radiology, and Society of Breast Imaging continue to recommend that women start getting annual mammograms at age 40. Additionally, as authorized by the Affordable Care Act, the United States Department of Health and Human Services continues to mandate that CMS pay for breast cancer screening based on the USPSTF 2002 guidelines (age 40, every 1-2 years).

The USPSTF 2009 guidelines did not take into account the current use of digital technology in mammographic screening, which has improved outcomes. The 2009 data no longer reflect how mammography is performed in the United States (Hendrick, Helvie. Mammography screening: a new estimate of the number needed to screen to prevent one breast cancer death. AJR 2012; 198:723-728). New CISNET (Cancer Intervention and Surveillance Modeling Network) data shows the impact of digital mammography (Ann Intern Med 2012;156:609-617, Table 3). This data shows 1.7 deaths are averted/1000 women screened over the course of the decade of 40-49. This equates to a number needed to screen (NNS) of 588. NNS is a primary metric for the USPFTF and this new number is far less than the number needed to invite (NNI) of 1904 used by the task force in 2009. Annual digital mammography averts 42% more breast cancer deaths (1.2 v 1.7/1000) than biennial mammography.

In addition, it is extremely important to consider life years gained (LYG), not just mortality data, especially for younger women, who have more life years gained from early detection and deaths averted. In the article noted above (Ann Intern Med 2012;156:609-617, Table 2), it was shown that for women in their 40s, annual screening results in 51 LYG/1000 women screened compared to 36 LYG for biennial screening in the same age group, a 42% improvement. For comparison, the expected benefit for biennial screening of women 50-74 is 44 LYG/1000 women screened. The 51 LYG per annual screening benefit in this decade of the 40s exceeds the LYG per decade of USPSTF biennial screening age 50-74.

Based on evidence from multiple randomized control trials, observational studies and CISNET modeling, the ACR guidelines recommend that asymptomatic women 40 years of age or older should have an annual screening mammogram. It is unclear at what age, if any, women cease to benefit from screening mammography. Because this age is likely to vary depending on the individual’s overall health, the decision as to when to stop routine mammography screening should be made on an individual basis by each woman and her physician. Our guideline is based on evidence from multiple randomized control trials and observational studies. Further sample references:

- Tabar et al. Swedish Two-County Trial: Impact of Mammographic Screening on Breast Cancer Mortality during 3 Decades Radiology September 2011 260:658-663; Published online June 28, 2011, doi:10.1148/radiol.11110469


Data from the above studies support the following points:

• There is increasing molecular and genetic information that tumors in younger women and African American women are more aggressive.

• Screening mammography shows greatest benefit—a 39.6 percent mortality reduction—from annual screening of women 40–84 years old. This screening regimen saves 71 percent more lives than (the USPSTF-recommended regimen of) biennial screening of women 50–74 years old, which had a 23.2 percent mortality reduction. By not getting a yearly mammogram after age 40, women increase their odds of dying from breast cancer.

• One in six breast cancers occur in women in their 40s.

• The ten year risk for breast cancer in a 40 year old woman is 1 in 69 and increases with age.

• 40 percent of all the years of life saved by mammography are for women in their 40s.

• Women at elevated risk for breast cancer due to strong family history or other reasons should speak with their doctor about starting mammographic screening earlier than age 40 and utilizing additional strategies such as screening with supplemental modalities.
• Approximately 75 percent of women diagnosed with breast cancer have no family history of breast cancer or other factors that put them at high risk for developing the disease so screening only high risk women misses the majority of cancers.

• If USPSTF breast cancer screening guidelines were followed, approximately 6,500 additional women each year in the U.S. would die from breast cancer.

• The largest (Hellquist et al) and longest running (Tabar et al) breast cancer screening studies, confirmed that regular mammography screening cut breast cancer deaths by roughly a third in all women ages 40 and over (including women ages 40-49). The magnitude of this benefit is twice that estimated by the USPSTF for women in their forties, changing the risk benefit ratio used for their recommendations.

**Numerator Time Frame**

We would like to emphasize that the CISNET models used by USPSTF did not model based on a 30 month screening interval. 30 months is too wide an interval even if the desire is to target a 24 month screening interval. The association of more rapidly progressive tumors in younger women -- pure numbers of malignancies and wider inter-screen timelines as defining numerators and denominators- will be dangerous.

**Numerator Language**

Allowing the numerator to include “one or more” mammograms versus the singular “a” is preferred. HHS supports the provision of a mammogram every 1 or 2 years, based on 2002 USPSTF recommendations.

The USPSTF endorsed a woman's right to choose to be screened during her forties, recommending that a process of shared decision making take place, stating “the decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient’s values regarding scientific benefits and harms.”

The ACR and SBI propose a change in the approach to measuring compliance with the breast cancer screening guidelines by tracking a pair of measures to inform how screening decisions are made by patients and providers. This will allow the health care system to generate data on shared decision making by patients and providers, and compliance with recommendations.

• Measure 1: Percent of women aged 40 and older (or aged 42 to allow look back for last 2 years) who have documentation of a current mammogram, by age (enabling analysis of mammography use rates by age).

• Measure 2: Percent of women aged 40 (42) and older, in different age ranges, who have had a documented discussion with their health care provider within the past 2 years about the benefits and harms of screening mammography as well as a discussion about the patient’s own risk of developing breast cancer.
We find the changes to the measure discouraging. HEDIS measures were developed to encourage practicing physicians to provide higher quality medical care. Each of the three proposed changes would reduce the effectiveness of the breast screening measure by re-setting the cut point. To the extent that practicing physicians attempt to meet HEDIS guidelines, the proposed changes would result in less screening, which would be detrimental to women's health.

Again, thank you for the opportunity to comment. If you have questions, please contact Judy Burleson at jburleson@acr.org or Yasmeen Fields at yfields@sbi-online.org.

Sincerely,

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