Breast Cancer Screening Workgroup #1 Meeting Summary

Wave 7 PCMP Episode-Based Cost Measure Clinician Expert Workgroup Workgroup Webinar, July 29, 2025

September 2025

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Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC to develop episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS) to meet the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Acumen's measure development approach involves convening clinician expert panels to provide input in cycles of development ("Waves").[1] In Wave 7, we obtained input on candidate clinical areas and episode groups through a public comment period from January 3 to January 24, 2025.[2] We developed prioritization criteria used to identify strong candidate episode groups and concepts based on input from our technical expert panel (TEP), Person and Family Engagement (PFE), Clinical Subcommittees (CS), and Clinician Expert Workgroups ("workgroups"). The Breast Cancer Screening episode group was selected for development based on the prioritization criteria, prior input received, and discussions with CMS.

We held a nomination period for workgroup members between June 2 and June 23, 2025. We finalized the Breast Cancer Screening Workgroup with 19 members in July 2025. The workgroup is composed of clinicians with expertise directly relevant to Breast Cancer Screening. They met virtually on July, 29, 2025 and provided detailed input on the development of the Breast Cancer Screening episode-based cost measure. The Workgroup will convene for a second and third meeting to continue measure specification and refinement discussions before and after a national field test, which is currently slated for early 2026.

Breast Cancer Screening Workgroup Meeting #1, July 29, 2025

This meeting summary document outlines the purpose, discussion, and recommendations from the Breast Cancer Screening Workgroup Meeting #1. Section 1 provides an overview of the

[1] For information on measure development in Wave 6, refer to the Wave 6 Measure Development Process document (https://www.cms.gov/files/document/2024-02-cmft-ebcm-process.pdf).

[2] For a summary of comments we received during the public comment period, refer to the Wave 7 Public Comment Summary Report (https://www.cms.gov/files/document/wave-7-public-comment-summary-report.pdf).

webinar goals and process. Section 2 summarizes the discussion and recommendations from the Workgroup.

1. Overview

The goals of the Breast Cancer Screening Workgroup Meeting #1 Webinar were the following:

(i) Review PFP findings,
(ii) Review draft measure specifications, including the episode-based cost measure framework and unique features for breast cancer screening,
(iii) Review prior interested party input, and
(iv) Discuss priority topic areas and recommendations on measure specifications, including: (1) clinician attribution and roles; (2) patient heterogeneity; and (3) service assignment and measure calculation; and (4) measure use and usability.

The meeting was held online via webinar and attended by 17 of the 19 workgroup members. The webinar was facilitated by Acumen moderator, Heather Litvinoff. The Breast Cancer Screening Workgroup chair was Dr. David Seidenwurm, who also facilitated meeting discussions. The PCMP Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[3]

All interested parties beyond the workgroup members had access to a public dial-in number to observe the meeting as part of Acumen's continued effort to increase the transparency of the measure development process.

Prior to the webinar, workgroup members were provided with information and materials to inform their meeting discussions. This includes a meeting agenda, slide deck, and a sub-population analysis. This analysis provided data on the frequency and cost associated with a set of sub-populations to support discussions regarding accounting for patient heterogeneity. After the webinar, workgroup members were sent a recording of the webinar and were polled on their preferences to ensure the measures are developed based on well-documented input. Based on similar meeting discussion practices, the threshold for support was >60% consensus among poll responses. This document summarizes the workgroup members' input from both the discussion as well as the polls.

This meeting was convened by Acumen as part of the measure development process to gather expert clinical input; as such, these are preliminary discussions and materials, which do not represent any final decisions about the measure specifications or MIPS.

2. Summary of Sessions and Discussion

This section is organized based on meeting sessions and describes workgroup member discussions and recommendations. The first sub-section summarizes the PFP findings discussed during the webinar. The remaining sub-sections describe workgroup member discussions and recommendations on clinician attribution, patient heterogeneity, service assignment, and measure use and usability, respectively. The final sub-section provides an overview of next steps for the measure development process.

[3] CMS, "PCMP Episode-Based Cost Measures Wave 7 Clinician Expert Workgroup Composition (Membership) List" https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/current.

2.1 Person and Family Partner (PFP) Findings and Discussion

We conducted focus groups and interviews with 6 PFPs to gather input that would inform cost measure development for the Breast Cancer Screening measure. During the webinar, 2 PFPs summarized these relevant findings and fielded questions from workgroup members.

PFPs outlined patient characteristics that influenced the frequency and outcome of their breast cancer screenings. Family history and history of other cancer led to more frequent screenings among the group. PFPs who experienced a false positive reading due to dense breast tissue required additional screening methods, including ultrasounds. In instances where this was a reoccurring issue, PFPs expressed that their care could improve in efficiency if they were able to receive an ultrasound first before a screening mammogram. Furthermore, PFPs highlighted that age and living in a rural community were barriers to receiving a screening mammogram. One PFP stated that their mother did not receive screening mammograms after age 75; the PFP reported that their mother's clinician based this decision on Medicare payment policies. While Medicare coverage of screening mammograms is not limited to a certain age range, the U.S. Preventative Task Force does not currently recommend screening mammograms after age 74.[4,5] Specifically, the guidelines state that current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years or older.[6] Workgroup members acknowledged that there are discrepancies among professional societies about whether to provide screening mammograms after age 74. Workgroup members also emphasized that the decision to stop receiving screening mammograms should be a result of a shared decision-making between patients and providers.

Additionally, PFPs reported a variety of medical specialties contributed to their breast cancer screening, diagnosis, and if necessary, cancer treatment. Many PFPs reported that their primary care physicians were most often responsible for ordering mammograms, whether it was preventative or in response to symptoms. In instances where PFPs did have a positive cancer diagnosis, they reported receiving care from specialists including hematologist-oncologists, OB/GYN surgeons, cancer center teams, cardiologists, pulmonologists, and physical therapists. PFPs reported that they did not directly communicate with the radiologist who read their screening mammograms.

Relatedly, PFPs discussed the importance of care coordination and communication between providers and patients. PFPs found that proactive primary care providers supported good care communication. PFPs also reported that integrated health systems, such as systems where all primary care diagnostic services and oncology care teams were co-located, resulted in better communication and substantially faster treatment. They emphasized the importance of a single electronic charting system, as it provides easier access to information for patients and providers. A PFP stated that patients in rural areas often do not have access to central electronic charting systems or screening centers. As a result, the PFP stated that the burden of care coordination often fell on the patient or family caregivers. For example, the PFP reported to print results from various patient portals, and carry hard copies of health records to her primary care provider to facilitate care.

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[4] CMS, National Coverage Determination (NCD) 220.4: Mammograms (*https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=186*).

[5] US Preventive Services Task Force. Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement. JAMA. 2024;331(22):1918–1930. doi:10.1001/jama.2024.5534

[6] Ibid.

PFPs also suggested several steps to improve quality of care, including customized follow-up screening or diagnostic protocols that take into account individual differences (e.g., dense breast tissue), more timely updates on screening results, direct communication from radiologists, and scheduling follow-up services in quick succession to reduce wait times and patient anxiety. Workgroup members noted that there can be limitations in guidelines and requirements for radiologists and other providers. For example, a screening mammogram is always the first service ordered, and then may be followed by supplemental imaging modalities (e.g., ultrasounds). Additionally, workgroup members stated that when performing diagnostic procedures (e.g., biopsies), radiologists engage with all patients and frequently discuss results. However, Workgroup members also discussed that there are gaps in communication and shared understanding between providers and patients that providers can work to better address. They acknowledged that often patients and providers use different language, which can undermine these shared understandings. Workgroup members discussed that hearing PFP experiences emphasized opportunities for clearer communication from providers around screening and diagnostic mammograms.

2.2 Attributing the Episode to Clinicians and Clinician Groups

During this section, Acumen presented an overview of the current trigger and attribution methodology and solicited feedback from workgroup members on whether the appropriate procedures and clinicians are being assessed by the measure.

First, Acumen reviewed the draft methodology for identifying and attributing Breast Cancer Screening episodes to clinicians (identified by their Tax Identification Number National Provider Number [TIN-NPI]) and groups (identified by their TIN). Cost measures identify a patient-clinician relationship by triggering an episode of care for a particular condition or procedure using the presence of related service and diagnosis codes on claims billed by the same clinician (as identified by their Tax Identification Number National Provider Number [TIN-NPI]). The Workgroup discussed whether the draft measure specifications were appropriately capturing clinician populations responsible for breast cancer screenings.

In the draft Breast Cancer Screening measure, episodes are attributed to clinician billing a trigger code for screening digital breast tomosynthesis or screening mammography. Clinician groups (as identified by their TIN) are attributed the aggregate of all episodes attributed to TIN-NPIs belonging to that TIN. If the same episode is attributed to more than one TIN-NPI within a TIN, the episode is only attributed once to that TIN.

Next, Acumen presented preliminary analyses assessing the most frequently attributed specialties. The highest attributed specialty is diagnostic radiologists, making up 78% of all attributed clinicians who performed more than 10 screenings (i.e., met a testing case minimum of 10) and are attributed approximately 96% of all breast cancer screening episodes. Testing demonstrated that other clinicians were also captured by the measure (i.e., OB/GYNs, primary care practitioners, and internal medicine physicians). Acumen clarified that non-radiology specialties would only be attributed if they billed for screening mammograms.

Workgroup members generally supported the current trigger and attribution methodology. Regarding the trigger methodology, workgroup members agreed with including standard and 3D mammography (i.e., digital tomosynthesis). Workgroup members also agreed with limiting the trigger diagnoses to screening versus diagnostic mammograms. One workgroup member expressed interested in seeing a comparison of episodes costs for the two trigger codes, which Acumen can explore for future meetings.

The Workgroup agreed that the measure appropriately captures diagnostic radiologists, and also generally agreed that it is appropriate to attribute episodes to the clinicians billing those codes. Some workgroup members speculated that additional specialties are being attributed the measure due to TIN structure and billing practices. The Workgroup expressed interest in having access to additional data exploring the spectrum of services provided by radiologists or by other attributed specialties to better understand the types of care provided by non-radiologists who are billing screening mammography codes. Acumen noted that the field testing period is an opportunity to for clinicians meeting the testing case minimum to review their field testing reports and provide feedback on the attribution methodology. Acumen will also explore additional testing for future workgroup meetings.

Key Takeaways from Discussion and/or Polls for Attributing the Clinician and Clinician Group:

- Members reached consensus that the measure is appropriately attributing clinicians who can reasonably influence costs related to breast cancer screening.
- Members agreed that radiologists play a central role in conducting screening mammograms as they are responsible for the accuracy of interpretations and determining further diagnostic workup if necessary.

2.3 Accounting for Patient Heterogeneity

In this section of the webinar, Acumen described the measure-specific methods for accounting for patient heterogeneity and solicited input from workgroup members on risk adjustment and exclusion variables.

Acumen reviewed the draft methodology for identifying sub-populations of the patient cohort that may have characteristics influencing expected costs. Table 1 provides further information about when to use each approach to account for heterogeneity, and also outlines the specific approach for the draft breast cancer screening measure specifications. Acumen also presented empirical analyses on the frequency, mean observed (expected) cost, and mean risk-adjusted (predicted) costs for each measure-specific risk adjustor.

Table 1: Methods for Accounting for Patient Heterogeneity

Method	Description	Draft Breast Cancer Screening Measure Specifications
Sub-Group	• If applicable, we may stratify the patient population into mutually exclusive and exhaustive sub-groups to define more homogenous patient cohorts. • Sub-grouping is a method that is intended for when we would want to compare episodes only with other similar episodes within the same sub-group. • This approach is used when sub-groups are very different from one another, and each sub-group requires its own risk adjustment model. • Since each sub-group will have its own risk adjustment model, the size of each sub-group should be sufficiently large.	The measure divides episodes into 2 sub-groups based on cancer detection:[7] • No breast cancer detected • Breast cancer detected

[7] Cancer detection is defined as two evaluation and management (E/M) services with a breast cancer diagnosis on two separate days or at least one breast cancer treatment service (e.g., mastectomy/lumpectomy, radiation treatment, chemotherapy).

Method	Description	Draft Breast Cancer Screening Measure Specifications
Risk Adjust	• We may define covariates in the risk adjustment model for the measure. • Risk adjusting is a method to account for the case-mix of patients and other non-clinical characteristics that influence complexity. It is meant to be used for sub-populations that make up a large share of patients who have a characteristic that is outside of the attributed clinician's reasonable influence. • Risk-adjusted cost measures adjust observed episode spending to expected episode spending (predicted by a risk adjustment model).	In addition to standard risk adjustors, the measure includes the following measure-specific risk adjustors: • BRCA carrier status • Dense breast tissue • History of abnormal mammogram • Family history of breast cancer
Exclude	• We may identify certain measure exclusions. • Excluding is a method in which we exclude certain patients or episodes to address issues with patient heterogeneity. This approach should be used when the sub-population affects a small, unique set of patients in which risk adjustment would not be sufficient to account for their differences in expected cost.	Measure-specific exclusions include the following: • Male patients • Patients under 40 years of age • Patients with a history of breast cancer
Monitor for Further Testing	• We may monitor certain sub-populations for further testing. • Monitoring for further testing is an option for flagging certain sub-populations that the Workgroup may revisit later during measure development upon review of further data. This approach is best used when the Workgroup requests additional data or information on a sub-population to discuss the appropriate method for meaningful clinical comparison.	The measure does not adjust for dual enrollment in Medicaid or other social risk factors based on prior input and testing.

Workgroup members generally agreed with the measure-specific risk adjustors, and that the risk adjustment methodology helps to neutralize differences between observed costs. Workgroup members also expressed support for the one-year lookback period applied to the measure's risk adjustment methodology. However, workgroup members discussed whether clinicians' coding practices may impact the measure's ability to identify sub-populations. Workgroup members questioned whether the frequency of episodes with dense breast tissue and history of abnormal mammogram should be higher, and whether this may be due to clinicians not including those diagnosis codes. Acumen clarified that the measure methodology may account for some of the low frequencies. For example, the measure only includes screening mammograms. Additionally, the measure excludes patients with a prior history of breast cancer, which may remove some patients with greater likelihood of having prior abnormal mammograms from the patient cohort.

Workgroup members questioned whether and how to include patients under 40 in the measure. The current measure excludes patients under 40. Workgroup members noted that this aligns with the current screening guidelines and also aligns with other related measures.

The workgroup also discussed the advantages and disadvantages of a claims-based measure, particularly as it relates to the methods for accounting for patient heterogeneity. Advantages includes consistent availability of data for all attributed clinicians and groups, as well as a reduced reporting burden. However, claims data does not have as much data as sources such as Electronic Health Records (EHRs).

<u>Key Takeaways from Discussion and/or Polls for Accounting for Patient Heterogeneity</u>:

- Members recommended continuing to sub-group episodes based on whether or not cancer is detected.
- Members were in favor identifying episodes with cancer detection by requiring evidence of at least one cancer treatment service or two E/M services with a cancer diagnosis.

- Members reached consensus that the draft measure exclusions (i.e., males, patients under 40, and patients with history of breast cancer) are appropriate and sufficient to account for patient heterogeneity that cannot be otherwise accounted for via other methods.
- Members reached consensus that the draft risk adjustment variables (i.e., standard cost measure risk adjustors, BRCA carrier status, dense breast tissue, history of abnormal mammogram, family history of breast cancer) are appropriate and sufficient to account for patient heterogeneity.

2.4 Identifying Clinically Related Services

During this section of the webinar, Acumen discussed the service assignment framework for the draft measure, and asked the workgroup to provide input on the types of services to assign to episodes.

Acumen outlined service assignment rules in the Breast Cancer Screening measure, which differ depending on cancer detection and timing (Table 2 and Table 3). Episode-based cost measures aim to only include clinically relevant costs whose occurrence, intensity, and/or frequency are within the reasonable influence of the attributed clinician. The Breast Cancer Screening measure currently assigns clinically-related costs in the 12 months following a screening mammogram. All breast cancer screening episodes include costs of basic diagnostic services (i.e., mammography, diagnostic ultrasound, breast biopsy, magnetic resonance imaging (MRI), and related office visits) and emergency department services related to screening mammography. Advanced diagnostic services and cancer treatment services are only assigned for late detection episodes. The measure intends to reward early and timely breast cancer diagnosis by ensuring that risk-adjusted costs for late breast cancer detection episodes are higher than those for early detection episodes.

Table 2: Breast Cancer Screening Service Categories for Early Detection or No Detection Episodes

Service Category	Clinically Assigned Services: For cancer detected within 8 months of screening mammogram or no cancer detected within 12 months of screening mammogram
Basic Diagnostic Services	• Mammography • Diagnostic ultrasound • Breast biopsy • Magnetic resonance imaging (MRI) • E/M services (encounter for screening mammogram)
ER Services	• Emergency department visit • Critical care services

Table 3: Breast Cancer Screening Service Categories for Late Detection Episodes

Service Category	Clinically Assigned Services: For cancer detected between 8-12 months of screening mammogram
Basic Diagnostic Services	• Mammography • Diagnostic ultrasound • Breast biopsy • Magnetic resonance imaging (MRI) • E/M services (encounter for screening mammogram)
ER Services	• Emergency department visit • Critical care services
Advanced Diagnostic Services	• Laboratory (chemistry and hematology) • Pathology • Computed tomography (CT) scan • Therapeutic procedures (physician dialysis services, desensitization, etc.)

Service Category	Clinically Assigned Services: For cancer detected between 8-12 months of screening mammogram
Treatment Services	• E/M services (with breast cancer diagnosis) • Breast biopsy, local excision, and other breast procedures • Mastectomy • Lumpectomy, quadrantectomy of breast • Cancer chemotherapy • Anesthesia • Non-hospital based care • Therapeutic radiology • Therapeutic procedures (skin and breast, female organs) • Ancillary services • Medications (injections, infusions, etc.) • Durable medical equipment and supplies • Hospitalizations (malignant breast disorders; septicemia or severe sepsis) • Complications of treatment (including hemorrhage)

2.4.1 Early Versus Late Cancer Detection

Acumen reviewed the current definitions for early and late cancer detection and solicited workgroup input on cancer detection and using an 8-month cut-off for early versus late detection.

Acumen noted that the draft specifications reflect testing showing that most cancer is detected within two months, but that there is also a small increase in detection around month six. The measure uses 8 months as a cut-off for early detection to allow sufficient time for diagnostic follow-up, as well as to account for cancers detected at 6-month follow-ups for indeterminate mammograms.

Acumen presented analyses demonstrating that episodes with a breast cancer detection make up less than 2% of all Breast Cancer Screening episodes. Workgroup members discussed whether the cancer detection rates aligned with their experiences and literature. Some workgroup members expected that the cancer detection rate would be lower. Others noted that cancer detection increases with age, so the rates may be reflective of the Medicare population.

Workgroup members also discussed whether 8 months is an appropriate cut-off. Some workgroup members noted that 8 months may be too long and that earlier detection should be incentivized. A member noted that from a patient-perspective, particularly those with aggressive cancers, detection should occur prior to 8 months. Other members questioned whether 8 months was too short to allow for 6-month follow-up diagnoses. Additionally, members noted that certain patient-level factors could influence follow-up care and diagnosis, such as:

- Patient behavior resulting in delayed follow-up,
- Differences in patient's ability to seek supplemental screenings not covered by Medicare, and
- Geographic location limiting access to follow-up care.

2.4.2 Mitigating Influence of Oncology Cost Variation on Measure Performance

Acumen reviewed service assignment steps for episodes with cancer detection, and asked workgroup members to provide feedback on the related measure construction steps.

Acumen presented preliminary analyses showing late detection episodes have a 70% increase in assigned costs compared to early detection episodes. Analyses also showed that, among late cancer detection episodes, cancers diagnosed earlier in the episode window had higher costs

even though an earlier diagnosis is generally preferred. For example, a detection in month 9 will have more time for costs to accrue than a detection in month 12. Acumen proposed several refinements to the measure methodology for assigning the costs of advanced diagnostic and treatment services (i.e., oncology costs) to late detection episodes. These included:

- Mitigating negative impact from high-cost outlier episodes (e.g., recommending a higher case minimum should the measure be implemented in MIPS),
- Reducing the influence of oncology costs on measure performance (e.g., apply a capped or fixed amount for oncology costs), and
- Addressing differences in cost based on detection month for the late detection group (e.g., extend service assignment window by a fixed length from cancer detection or apply a timing risk adjustor based on detection month).

Workgroup members discussed inclusion of advanced diagnostic and treatment costs for late detection episodes. Workgroup members generally agreed that early detection episodes should have lower risk-adjusted costs than late detection episodes, though they questioned whether the measure should be focusing on assessing attributed clinicians on early detection and sensitivity as a form of cost-efficiency. Workgroup members also noted that many factors can influence oncology costs, and those factors are typically not within the reasonable influence of the attributed clinician, supporting exploration of methods like assigning a capped or fixed cost for oncology treatment. For example, one workgroup member shared that variation in pathology costs are likely driven by practice patterns of other clinicians and groups. Acumen suggested that truncation or a fixed cost assigned to late detection episodes would address this variation in individual diagnostic and treatment service costs.

Key Takeaways from Discussion and/or Polls for Identifying Clinically Related Services:

- Members supported the service categories (i.e., basic diagnostic services, ER services, advanced diagnostic services, and treatment services) as currently defined.
- Members reached consensus to use a 12-month episode window to capture clinically-related costs and to apply an 8-month window for defining early or timely breast cancer detection episodes.
- Some members suggested adjusting for geographic location (e.g., urban/rural settings), as it can influence the timing of diagnosis or access to follow-up care.
- Members recommended testing methods to reduce the influence of variation in oncology costs such as assigning a fixed cost to late detection episodes.
- Members also recommended testing methods to address differences in cost based on detection month for late cancer detection episodes.

2.5 Measure Use and Usability

Throughout the webinar, members raised consideration of additional topics related to the measure's potential use and usability. For example, workgroup members discussed how the cost measure could be used alongside quality measures or incorporate certain quality aspects to promote value-based care. Workgroup members noted that aligned quality measures can help with reducing potential risk of care stinting. One workgroup member also noted that many other payers follow Medicare's lead for measurement, and questioned what impacts this measure could have outside of MIPS. Another workgroup member noted that while there is no reporting burden, clinicians may have to invest time and resources to improve cost efficiency and perform well on the measure. Additionally, Acumen and workgroup members reiterated that the measure is attributed to clinicians performing the screening mammogram, not the referring clinician, so the measure will not disincentivize referrals for screenings mammograms.

2.6 Next Steps

In the last session, Acumen provided an overview of the next steps. After the meeting, Acumen distributed the Workgroup Webinar Poll to gather input from members on the discussions held during the webinar. In this poll, we also asked workgroup members for their availability for the second webinar in September – October 2025. Acumen will operationalize input for the measure specifications based on webinar discussion and poll results and will follow-up with workgroup members with more information about the next steps in the measure development process.

Please contact **Acumen PCMP Workgroup Support** at pcmp-workgroup-support@acumenllc.com if you have any questions. If you are interested in receiving updates about MACRA Episode-Based Cost Measures, please complete this Mailing List Sign-Up Form to be added to our mailing list.