Breast Cancer Screening Workgroup #2 Meeting Summary

Wave 7 PCMP Episode-Based Cost Measure Clinician Expert Workgroup Workgroup Webinar, October 31, 2025

December 2025

Contents

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 October 31, 2025 to provide detailed input on the development of the Breast Cancer Screening episode-based cost measure. The Workgroup will

[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).

convene for a third meeting to continue measure specification and refinement discussions after a national field test, which is currently slated for early 2026.

Breast Cancer Screening Workgroup Meeting #2, October 31, 2025

This meeting summary document outlines the purpose, discussion, and recommendations from the Breast Cancer Screening Workgroup Meeting #2. Section 1 provides an overview of the webinar goals and process. Section 0 summarizes the discussion and recommendations from the Workgroup.

1. Overview

The goals of the Breast Cancer Screening Workgroup Meeting #2 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) Discuss priority topic areas and recommendations on measure specifications, including: (1) revisiting services used to trigger episodes; (2) addressing variation in oncology costs; and (3) exploring the influence of geographic location.

The meeting was held online via webinar and attended by 16 of the 19 workgroup members. Heather Litvinoff, of Acumen, moderated the meeting. Dr. David Seidenwurm served as the Breast Cancer Screening Workgroup chair and 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]

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 pair of sub-population analyses. The analyses provided data on the frequency and cost associated with a set of sub-populations for draft versions of the measure to support discussions regarding service assignment. After the webinar, workgroup members were sent a recording of the webinar, updated meeting materials, and were polled on their preferences to ensure the measure is developed based on well-documented input. At the request of the Workgroup, updated meeting materials and the poll contained additional testing results (i.e., using a 365-day lookback period for applicable measure-specific exclusions and risk adjustment variables). 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 the services used to trigger episodes, variation in

[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.

oncology costs, and the influence of geographic location on provider performance. The final sub-section provides an overview of next steps for the measure development process.

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 PFP representatives summarized relevant findings and fielded questions from workgroup members.

The PFP provided reflections on shared decision-making and care coordination. PFPs reported having positive experiences with clinicians that clearly presented options and explained outcomes of breast cancer screenings. PFPs noted that clinicians asking the right questions can better inform decision-making. PFPs also reported that feeling heard and respected by clinicians is essential. They highlighted that patient values and preferences guide care choices, such as opting out of magnetic resonance imaging (MRIs) in favor of ultrasounds. Relatedly, PFPs discussed the importance of organization and communication between providers and patients. PFPs found that regular communication between primary care, specialists, and oncologists improves experiences with breast cancer screening. A few PFPs suggested that short appointment times limit understanding of next steps and recommended receiving pre-visit questions from clinicians to enhance the efficiency and clarity of the appointment.

PFPs shared a few barriers to breast cancer screening and follow-up care. PFPs reported having transportation and travel challenges, especially in rural areas. One PFP described coordinating appointments around the availability of their family members who provided transportation and support. Other barriers include health conditions (e.g., comorbidities), mobility limitations, lack of accessible exam tables, limited language access (e.g., lack of timely translation services), and lack of public or medical transport. Many PFPs emphasized that support from family or caregivers was critical for completing screenings and appointments.

2.2 Revisiting Services Used to Trigger Episodes

Acumen reviewed the measure's draft trigger methodology for identifying and attributing Breast Cancer Screening episodes and solicited feedback from workgroup members on the measure's trigger methodology. The draft measure uses the following two billing codes to open or "trigger" episodes:[4]

- CPT/HCPCS 77063: Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)
- CPT/HCPCS 77067: Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Acumen highlighted that the CPT code 77063 is an add-on code used to bill screening 3D mammography and, per Medicare coding guidance, should be listed in addition to the primary procedure code (i.e., CPT code 77067). Analyses showed that close to no Breast Cancer Screening episodes (0.06%) are triggered by only the add-on code 77063. Acumen noted that cost measures typically do not use add-on codes to trigger episodes as they may represent incorrect billing, incomplete episode information, and/or a redundant service when billed with the required code. Acumen also noted that the costs of screening 3D mammography are captured through the measure's service assignment rules. Therefore, Acumen proposed removing add-on code 77063 from the measure's trigger methodology.

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The Workgroup confirmed that billing the add-on code alone likely represents miscoding. Workgroup members acknowledged that the measure would capture accurate billing of 3D screening mammography since this service requires billing the primary procedure code (i.e., CPT code 77067).[5] All workgroup members present during the webinar voted to remove the add-on code 77063 from the measure's trigger methodology.

Acumen also reviewed the frequency and performance trends for episodes triggered by only screening 2D mammography (i.e., CPT code 77067) compared to those triggered by screening 2D and 3D mammography (i.e., CPT code 77067 and 77603). The majority of episodes (94.4%) have both CPT codes 77067 and 77063 billed on the day of the trigger event. Additionally, the majority of providers (77.7%) have over 90% of their episodes with both trigger codes. Episodes with both trigger codes billed had better performance on average when cancer was detection, and had worse performance when cancer was not detected.

Workgroup members discussed potential differences between billing both trigger codes versus only the primary procedure code. Workgroup members noted that screening 3D mammography has been adopted almost universally since 2011. However, workgroup members noted there are still providers (e.g., in rural areas) that continue to perform screening 2D mammography. Another workgroup member suggested potentially sub-grouping the trigger procedures to account for cost and performance differences between screening 2D mammography and 3D mammography.

Key Takeaways from Discussion and/or Polls for Revising Services Used to Trigger Episodes:

- The Workgroup reached consensus to remove the add-on code 77063 from the measure's trigger methodology, and agreed that billing this add-on code alone represents miscoding.

2.3 Addressing Variation in Oncology Costs and Differences in Cost by Detection Month

During this section of the webinar, Acumen reviewed the service assignment framework for the draft measure, and asked the workgroup to provide input on methods to reduce variation in oncology costs and address differences in cost based on detection month for late cancer detection 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). 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 and emergency department services related to screening mammography. Advanced diagnostic services and cancer treatment services are only assigned for late detection episodes, or when cancer is detected between 8-12 months of the screening mammogram (i.e., more than 240 days after the initial screening mammogram but within the 360-day episode window). The overall intent of the measure is to promote cost-efficient mammography and follow-up services, without disincentivizing efficient cancer detection or holding attributed clinicians responsible for cost variation outside their reasonable influence (i.e., variation in cancer treatment costs). This can be achieved by ensuring that risk-adjusted costs for late breast cancer detection episodes are higher than those for early detection episodes.

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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
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)

Acumen summarized preliminary findings from testing methods to reduce variation in oncology costs and address differences in cost based on detection month for late cancer detection episodes. Acumen noted that a fixed oncology cost successfully neutralized extreme differences across late detection episodes and requested input from the Workgroup on how to best determine a meaningful and representative fixed oncology cost. Additionally, Acumen shared that cost differences remain based on month of detection across early and late detection episodes. At the request of workgroup members, Acumen noted that updated testing results using a 365-day lookback period for measure risk adjustment variables and exclusions will be shared after the webinar.

As part of this discussion, workgroup members had additional discussions about the definition of early and late detection episodes. Some workgroup members questioned whether the measure is only classifying “missed” interval cancers as late detection, or whether “true” interval cancers might also be classified as late detection. Further, workgroup members expressed concerns that a late detection episode could be capturing cancer detection that appropriately occurs after a 6-

month follow-up mammogram. One workgroup member acknowledged limitations of using claims data to detect "missed" interval cancers, but also emphasized that rates of "true" interval cancers could be reasonably expected to be similar across clinicians, particularly after applying risk adjustment and exclusions for patient factors like breast dense tissue. Another workgroup member noted that while there may not be a significant cost difference between cancer detected within versus after 8 months of a screening mammogram, the diagnosis delay would be meaningful for patients. Some workgroup members suggested extending the episode window to 2 years, while another noted that MIPS is based on a year-long performance period, so limiting to a one-year episode window may be more feasible for program use.

The workgroup also discussed the proposed approaches for addressing variation in costs in early and late detection episodes. Some workgroup members verbally noted continued consensus that attributed clinicians should not be held accountable for costs outside their reasonable influence (i.e., variation in oncology cost) while still rewarding early detection and cost-efficient mammography. Workgroup members generally expressed interest in reviewing the data with a 365-day lookback applied to applicable exclusion and risk adjustment variables before recommending a specific methodology to achieve this desired outcome.

Additionally, the workgroup discussed potential unintended consequences of the measure, and whether these are mitigated by the measure's design. Some workgroup members questioned whether the measure could lead to inappropriate overuse of imaging to avoid late detection; another workgroup member clarified that the measure design protects against this by assessing the attributed clinician on follow-up imaging that occurs during the episode. Other workgroup members questioned whether differences in insurance or other factors may impact measure performance and patient access to care. Acumen clarified that the measure only includes patients with Traditional Fee-For-Service (FFS) Medicare, and noted that testing on patients dually-enrolled in Medicare and Medicaid will be incorporated into the field testing process. Acumen addressed performance for providers in rural versus urban locations in the next discussion section (Section 2.4).

Key Takeaways from Discussion and/or Polls for Addressing Variation in Oncology Costs:

- The Workgroup reached consensus to apply the fixed median oncology cost refinement across late detection episodes.
- Some members suggested further consideration of service assignment rules to better account for interval cancer.

2.4 Exploring the Influence of Geographic Location

In response to workgroup member input, Acumen examined provider performance by rural and urban setting. Acumen presented findings that indicated that providers in rural settings perform similarly to those in urban settings. When Acumen asked if the measure adequately accounts for the influence of geographic location, no workgroup members raised concerns.

Key Takeaways from Discussion and/or Polls for Exploring the Influence of Geographic Location:

- The Workgroup reached consensus that the measure adequately risk adjusts for the influence of geographic location (i.e., rural and urban) on provider performance.

2.5 Next Steps

In the last session, Acumen provided an overview of the next steps. Field testing for the Wave 6 and Wave 7 measures are slated to take place in early 2026, and Acumen is planning to make updates to the process based on feedback from prior field testing, such as (i) including more context and guidance on the report metrics and (ii) providing updated educational materials and outreach efforts to help clinicians and other interested parties understand the measure specifications and how to navigate the reports.

After the meeting, Acumen distributed the Workgroup Meeting #2 Poll, including additional data, to gather input from workgroup members on the discussion topics during the meeting. Acumen will operationalize input for the measure specifications based on the workgroup meeting 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 PCMP Episode-Based Cost Measures, please complete this Mailing List Sign-Up Form to be added to our mailing list.