



# Episode-Based Cost Measure (EBCM) At-A-Glance

## Breast Cancer Screening

### Overview

#### Measure Concept

- Around one third of women enrolled in Medicare fee-for-service have a screening mammogram each year
- Late or delayed detection of breast cancer is associated with more advanced stage cancers at diagnosis and increased risk of mortality
- Measure could be used with MIPS quality measures to assess overall value of care and has low reporting burden for clinicians
- Captures diagnostic radiologists, who do not currently have an applicable episode-based cost measure

#### Development & Input

- Clinical expert workgroup provided detailed input on all aspects of the measure over 12 months
  - ✓ 19 members representing 16 specialty societies
  - ✓ Member specialties include diagnostic radiology, oncology, internal medicine, family practice, nurse practitioner, obstetrics & gynecology, pathology
- Nation-wide field testing/public comment opportunity in January and February 2026 gathered broad input on measure specs, testing, and informational reports
- Persons with lived experience provided input to the workgroup and during public comment



#### Measure Features & Calculation

- Measure evaluates a clinician or group on the costs of breast cancer screenings for women 40 years of age or older during a performance period
- *Only* includes costs *clinically related* to the screening mammogram which triggers an episode of care
- Costs are *risk adjusted*, which allows fairer comparisons and accounts for differences in patient cohorts (e.g., family history of breast cancer, prior presence of dense breast tissue, comorbidities)
- Measure calculated as comparison (ratio) of observed costs to expected costs, across all attributed episodes
  - ✓ Observed costs are *actual* payment-standardized costs for related care
  - ✓ Expected costs are how much it would be *expected* to cost to treat each patient after accounting for their unique disease severity and comorbidities
- A lower score is better, and means that, on average, a clinician's observed costs were lower than expected

Top  
Specialty

Diagnostic  
Radiology



### Measure Importance & Impact

Evaluates care provided across many patients & clinicians



4,164,160  
episodes



4,150,266  
patients

(10-episode testing threshold)



17,464 clinicians



2,369 groups

### Opportunities for Improvement

Examples of Included Service Costs	Basic Diagnostic Services (e.g., mammography, breast biopsy)	Advanced Diagnostic Services (e.g., laboratory and pathology)	Cancer Treatment Services <i>Assigned as fixed cost to late detection episodes only</i>
Potential Improvement Opportunities	<ul style="list-style-type: none"><li>• Provide screenings to women aged 40 years or older at least biennially per Clinical Practice Guidelines (CPG)</li><li>• Consider supplemental imaging (e.g., ultrasounds, MRIs) to reduce false positives</li><li>• Leverage artificial intelligence (AI) models to improve the accuracy of cancer detection</li></ul>	<ul style="list-style-type: none"><li>• Identify women that are high risk (e.g., have dense breasts) to tailor diagnosis and treatment plans</li><li>• Schedule follow-up testing in a timely manner to decrease patient burden and costs</li><li>• Engage in shared decision-making to ensure informed and patient-centered care</li></ul>	<ul style="list-style-type: none"><li>• Implement performance benchmarks to reduce late or missed cancer detections which lead to increased cancer treatment costs</li><li>• Improve care coordination to avoid overtreatment, reduce barriers to care, and encourage early detection of breast cancer</li></ul>



Refer to the *Measure Information Form (MIF)* or *Measure Codes List* for more information on measure specifications and included costs on the [CMS.gov Cost Measures Information Page](https://www.cms.gov/medicare/coverage/claims/article.aspx?pubid=1000).



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## Testing and Acceptability

### Performance Gap & Improvement Opportunity | sufficient variation

Distribution of scores across the most and least efficient clinicians helps to understand if the measure is useful to understand cost performance and incentivize improvements.

- ✓ 90<sup>th</sup> percentile is more than 35% greater than 10<sup>th</sup> percentile score for groups and clinicians
- ✓ There is variation in clinician performance, and therefore, opportunity for improvement

		Distribution Across Percentiles					
		Level	10 <sup>th</sup>	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>
Average Risk Adjusted Cost							
Groups	\$221	Group	\$179	\$207	\$222	\$237	\$258
Clinicians	\$223	Clinician	\$191	\$206	\$222	\$238	\$259

### Validity | accuracy in measuring what we intend



Results show the measure assesses the costs of services associated with breast cancer screening, including (i) screening mammography and basic diagnostic services for all episodes, and (ii) additional services for episodes with late cancer detection.

As expected, groups and clinicians tend to have better cost performance for episodes with no cancer detection or early cancer detection.

Groups' and clinicians' mean observed to expected cost ratios for **late detection episodes** are on average **more than 2x higher** than **early detection episodes**.



### Dual Status and Provider Location | evaluating appropriateness for risk adjustment

Beyond clinical characteristics of patients, the cost of care may be influenced by non-clinical factors such as location or coverage eligibility. Testing helps evaluate whether incorporating risk adjustment for dual enrollment in Medicare and Medicaid or provider location (rural versus urban) is necessary to improve measure fairness and whether adjustment would limit the ability to distinguish true differences in clinician performance.

The draft measure specifications do not include an adjustment for episodes where patients have dual enrollment status because:

- ✓ Most clinicians perform equally well on dual and non-dual episodes (93%). Additionally, about as many clinicians perform significantly worse on dual episodes (4%) as perform significantly better (3%).
- ✓ Some clinicians see their scores shift 1 percentile or more after adjusting for dual status (17%), but fewer clinicians see their scores shift 5 percentiles or more (0.1%).

The measure does not adjust for provider location, as performance is similar in rural and urban locations for groups (average rural risk adjusted cost: \$217, average urban risk adjusted cost: \$223) and clinicians (average rural risk adjusted cost: \$220, average urban risk adjusted cost: \$223).

### Reliability | consistency in repeat measurements

At a 10-episode testing threshold, the mean reliability is **high**. This measure assesses meaningful differences in clinician performance.

**Groups 0.98**

**Clinicians 0.92**



Results across all tests should be considered together rather than in isolation. Excerpted results are shared above; refer to the Measure Testing Form on the [CMS.gov Cost Measures Information Page](#) for full details and additional results.