# Breast Cancer Screening Episode-Based Cost Measure

## Measure Information Form (MIF)

May 2024

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# 1.0 Introduction

This document details the methodology for the Breast Cancer Screening episode-based cost measure and should be reviewed along with the Breast Cancer Screening Measure Codes List file, which contains the codes used in constructing the measure.

## 1.1 Measure Name

Breast Cancer Screening episode-based cost measure

## 1.2 Measure Description

This episode-based cost measure represents the cost to Medicare for the items and services provided to a patient during an episode of care ("episode"). In all supplemental documentation, "cost" generally means the Medicare claims amount that has been modified to remove geographic factors and variation, and claims data from Medicare Parts A and B are used to construct this episode-based cost measure. This measure is specific to the Medicare population.

The Breast Cancer Screening episode-based cost measure evaluates a clinician's average risk-adjusted cost to Medicare for care provision in women 40 years of age or older who received a screening mammogram during an episode of care. The measure score is the clinician's risk-adjusted cost for the episode group averaged across all episodes attributed to the clinician. This measure includes costs of services that are clinically related to the attributed clinician's role in managing care during each episode starting from the screening mammogram that opens, or "triggers," the episode through 12 months after the trigger or the next screening mammogram.

## 1.3 Measure Rationale

Women have a 1 in 8 chance of developing breast cancer during their lives.[1] According to the American Cancer Society, breast cancer found during screening before symptoms appear is more likely to be smaller and less likely to have spread beyond the breast. This makes it easier to treat successfully and is likely to have a better prognosis for the patient. As such, early detection is one of the most important strategies for preventing deaths from breast cancer,[2] the second leading cause of cancer death in women in the United States.[3]

Screening mammography reduces breast cancer mortality by an estimated 20%-35% in women aged 50-69 years.[4] However, two challenges with screening mammography are false negatives and false positives. Screening mammograms miss an estimated one in eight breast cancers; research indicates that 1.3%-45% of missed cancers were visible on mammograms.[5] False positives are common; around half of all women getting annual mammograms over a 10-year period will have a false positive finding, which can result in unnecessary testing and patient

[1] American Cancer Society. Key statistics for breast cancer. Accessed May 15, 2022. https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html

[2] American Cancer Society. Recommendations for the early detection of breast cancer. Accessed May 15, 2022. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html

[3] American Cancer Society. Key statistics for breast cancer. Accessed May 15, 2022. https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html

[4] Elmore JG, Armstrong K, Lehman CD, Fletcher SW. Screening for breast cancer. *JAMA*. 2005;293(10):1245-1256. doi:10.1001/jama.293.10.1245.

[5] Ekpo EU, Alakhras M, Brennan P. Errors in mammography cannot be solved through technology alone. *Asian Pac J Cancer Prev.* 2018;19(2):291-301. doi:10.22034/APJCP.2018.19.2.291.

anxiety.[6] To balance the risks of false negatives and false positives, organizations have defined key metrics and developed acceptable ranges for breast cancer screening and diagnosis. Use of these has been associated with improvements in breast imaging programs.[7]

The Breast Cancer Screening episode-based cost measure was developed with input from a Technical Expert Panel (TEP) composed of clinical experts, as well as patients, caregivers, and patient advocates. This measure focuses on the clinical topic of breast cancer screening and fills critical measurement gaps.

## 1.4 Measure Numerator

The cost measure numerator is the sum of the ratio of observed to expected[8] cost to Medicare for all Breast Cancer Screening episodes attributed to a clinician. This sum is then multiplied by the national average observed episode cost to generate a dollar figure.

## 1.5 Measure Denominator

The cost measure denominator is the total number of episodes from the Breast Cancer Screening episode group attributed to a clinician.

## 1.6 Data Sources

The Breast Cancer Screening cost measure uses the following data sources:

- Medicare inpatient, outpatient, and physician/supplier Part B claims
- Data from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC)
- Enrollment information from Master Beneficiary Summary File (MBSF)

## 1.7 Care Settings

Methodologically, the Breast Cancer Screening cost measure can be triggered based on Physician/Carrier (PB) claims that indicate patient services for a screening mammogram.

## 1.8 Cohort

The cohort for this cost measure consists of women 40 years of age or older who are Medicare beneficiaries enrolled in Medicare fee-for-service and who undergo a breast cancer screening mammogram that triggers a Breast Cancer Screening episode. The cohort for this cost measure is also further refined by the definition of the episode group and measure-specific exclusions (refer to Section 4.0).

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[6] American Cancer Society. Limitations of mammograms. Accessed May 15, 2022. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/mammograms/limitations-of-mammograms.html

[7] Hussain S, Omar A, Shah BA. The breast imaging medical audit: what the radiologist needs to know. *Contemp Diagn Radiol.* 2021;44(8):1-6.

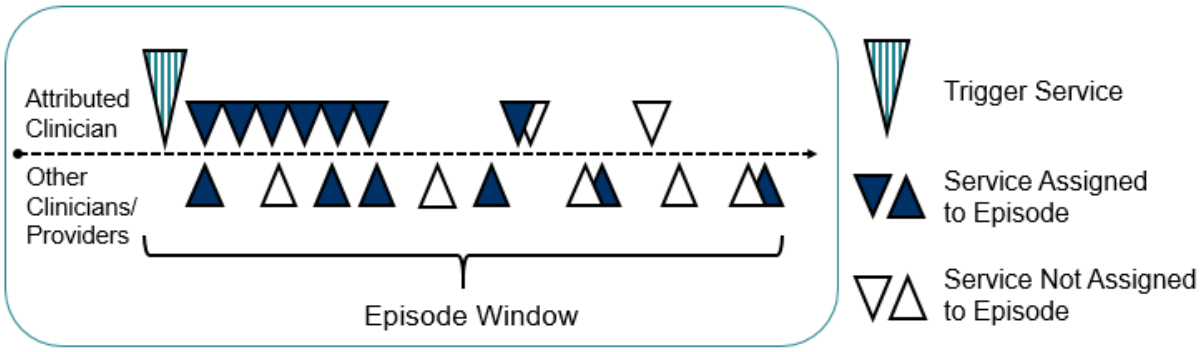
[8] Expected costs refer to costs predicted by the risk adjustment model. For more information on expected costs and risk adjustment, please refer to Section 4.5.

# 2.0 Methodology Steps

There are 2 overarching processes in calculating episode-based cost measure scores: episode construction (Steps 1-3) and measure calculation (Steps 4-6). This section provides a brief one-page summary of these processes for the Breast Cancer Screening cost measure. Section 4.0 describes the processes in detail.

1. **Trigger and define an episode**: Episodes are defined by billing codes that open, or "trigger," an episode. The episode window starts the day of the trigger event (screening mammogram) and ends 12 months after the trigger or the next screening mammogram (Figure 1). To enable meaningful clinical comparisons, episodes are placed into more granular, mutually exclusive and exhaustive sub-groups based on clinical criteria. Some episodes may be excluded based on other information available at the time of the trigger.
2. **Attribute the episode to a clinician**: An attributed clinician is any clinician who bills a trigger code for the episode group on the day of the screening mammogram.
3. **Assign costs to the episode and calculate the episode observed cost**: Clinically related services occurring during the episode window are assigned to the episode. The cost of the assigned services is summed to determine each episode's standardized observed cost.

**Figure 1. Diagram Showing an Example of a Constructed Episode**




4. **Exclude episodes**: Exclusions remove unique groups of patients from cost measure calculation in cases where it may be impractical and unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
5. **Calculate expected costs for risk adjustment**: Risk adjustment aims to isolate variation in clinician costs to only the costs that clinicians can reasonably influence (e.g., adjusting for patient age, comorbidities and other factors). A regression analysis is run using the risk adjustment variables as covariates to estimate the expected cost of each episode. Then, statistical techniques are applied to reduce the effect of extreme outliers on measure scores.
6. **Calculate the measure score:** For each episode, the ratio of total observed cost without geographical variation (from Step 3) to risk-adjusted expected cost (from Step 5) is calculated and averaged across all of a clinician's or clinician group's attributed episodes to obtain the average episode cost ratio. The average episode cost ratio is multiplied by the national average observed episode cost to generate a dollar figure for the cost measure score.

# 3.0 Measure Specifications Quick Reference

This section provides a quick, at-a-glance reference for the Breast Cancer Screening episode-based cost measure specifications. More details on each component can be found in Section 4.0, and the full list of codes and logic used to define each component can be found within the Cost Measure Codes List file.

**Episode Window**: During what time period are costs measured?

Episode Start Date: Day of trigger event (screening mammogram)

Episode End Date: 12 months after trigger or the next screening mammogram

**Triggers**: Patients receiving what medical care are included in the measure?

- Current Procedural Terminology / Healthcare Common Procedure Coding System (CPT/HCPCS) codes for a screening mammogram: CPT/HCPCS codes 77063, 77067

**Sub-groups**: What are the mutually exclusive types of episodes?

1. Breast cancer detection
2. No breast cancer detection

**Service Assignment**: Which clinically related costs are included in the measure?

Assigned services generally fall within the following categories:

- Basic diagnostic services (including, but not limited to): mammography, diagnostic ultrasound
- Advanced diagnostic services (including, but not limited to): pathology (including surgical pathology), genetic testing
- Treatment services (including, but not limited to): chemotherapy, anesthesia, mastectomy

The service assignment rule assigns only the costs of basic diagnostic services to early breast cancer detection episodes, which are episodes with a breast cancer detection within eight months of a screening mammogram. The costs of basic diagnostic services, advanced diagnostic services, and treatment services are assigned to late breast cancer detection episodes, which are episodes with a breast cancer detection after eight months of the screening mammogram.

**Risk Adjustors**: Which risk factors are accounted for in the risk adjustment model?

- Standard risk adjustors, including comorbidities captured by Hierarchical Condition Category (HCC) codes based on CMS-HCC V24, interaction variables accounting for a range of comorbidities, patient age category, and patient disability status.
- Measure-specific risk adjustors including patients with a history of genetic risk of breast cancer (BRCA [breast cancer gene] carrier status), prior presence of dense breast tissue, history of abnormal mammogram, and family history of breast cancer.
- For the full list of standard and measure-specific risk adjustment variables, please reference the “RA” and “RA_Details” tabs of the Cost Measure Codes List file.

**Exclusions**: Which populations are excluded from measure calculation?

- Standard exclusions to ensure data completeness:
  - The patient was not found in MBSF.
  - The patient resides outside of the United States or its territories.
  - The patient’s date of birth is missing.
  - The patient was not continuously enrolled in Medicare Parts A and B for the entirety of the lookback period plus episode window, or was enrolled in Part C for any part of the lookback plus episode window.
  - The patient’s death date occurred during the episode.
  - The patient has extremely low costs.

- Measure-specific exclusions, including male patients, patients under 40 years of age, and patients with a history of breast cancer. For the full list of measure-specific exclusions, please reference the “Exclusions” and “Exclusions_Details” tabs of the Cost Measure Codes List file.

# 4.0 Detailed Measure Methodology

This section contains the technical details for the 2 overarching processes in calculating episode-based cost measure scores in more detail: Sections 4.1 through 4.3 describe episode construction and Sections 4.4 through 4.6 describe measure calculation.

## 4.1 Trigger and Define an Episode

Breast Cancer Screening episodes are defined by Current Procedural Terminology / Healthcare Common Procedure Coding System (CPT/HCPCS) codes on Part B Physician/Supplier (Carrier) claims that open, or trigger, an episode. For the codes and logic relevant to this section please refer to the “Triggers” tab in the Breast Cancer Screening Cost Measure Codes List.

The steps for defining an episode for the Breast Cancer Screening episode group are as follows:

- **Identify** Part B Physician/Supplier claim lines with positive standardized payment that have a trigger code.
- **Trigger** an episode if all the following conditions are met for an identified Part B Physician/Supplier claim line:
    - It was billed by a clinician of a specialty that is eligible for MIPS.
    - It is the highest cost claim line across all claim lines identified in the above bullets and that have any Breast Cancer Screening trigger code billed for the patient on that day.
- **Establish** the episode window as follows:
    - Establish the episode trigger date as the expense date of the trigger claim line identified in the "Trigger an episode" bullet above.
    - Establish the episode start date as the day of the episode trigger date.
    - Establish the episode end date as 12 months after the episode trigger date or the next screening mammogram.

Once a Breast Cancer Screening episode is triggered, the episode is placed into one of the episode sub-groups to enable meaningful clinical comparisons. Sub-groups represent more granular, mutually exclusive and exhaustive patient populations defined by clinical criteria (e.g., information available on the patient’s claims at the time of the trigger). Sub-groups are useful in ensuring clinical comparability so that the corresponding cost measure fairly compares clinicians with a similar patient case-mix.

Codes used to define the sub-groups can be found in the “Sub_Groups_Details” tab of the Breast Cancer Screening Cost Measure Codes List file. This cost measure has 2 sub-groups:

- Breast Cancer Detection
    - The Breast Cancer Detection sub-group is designated by breast cancer treatment or two evaluation and management (E/M) services with a breast cancer diagnosis on two separate days.
- No Breast Cancer Detection
    - The No Breast Cancer Detection sub-group is the counterpart of the Breast Cancer Detection sub-group. The No Breast Cancer Detection sub-group is designated by no breast cancer treatment or E/M services with a breast cancer diagnosis.

## 4.2 Attribute Episodes to a Clinician

Once an episode has been triggered and defined, it is attributed to one or more clinicians of a specialty that is eligible for MIPS. Clinicians are identified by Taxpayer Identification Number

(TIN) and National Provider Identifier (NPI) pairs (TIN-NPI), and clinician groups are identified by TIN. Only clinicians of a specialty that is eligible for MIPS or clinician groups where the triggering clinician is of a specialty that is eligible for MIPS are attributed episodes. For codes relevant to this section, please see the "Attribution" tab of the Breast Cancer Screening Cost Measure Codes List.

The steps for attributing a Breast Cancer Screening episode are as follows:

- **Identify** claim lines with positive payment for any trigger codes that occur on the episode trigger day.
- **Designate** a TIN-NPI as a main clinician if the following conditions are met:
    - No assistant modifier code is found on one or more claim lines billed by the clinician.
    - No exclusion modifier code is found on the same claim line.
- **Designate** a TIN-NPI as an assistant clinician if the following conditions are met:
    - The TIN-NPI was not designated as a main clinician.
    - An assistant modifier code is found.
    - No exclusion modifier code is found.
- **Attribute** an episode to any TIN-NPI designated as a main clinician.
- **Attribute** episodes to the TIN by aggregating all episodes attributed to NPIs that bill to that TIN. If the same episode is attributed to more than one NPI within a TIN, the episode is attributed only once to that TIN.[9]

## 4.3 Assign Costs to an Episode and Calculate Total Observed Episode Cost

Services, and their Medicare costs, are assigned to an episode only when clinically related to the attributed clinician's role in managing patient care during the episode. Assigned services may include treatment and diagnostic services, ancillary items, services directly related to treatment, and those furnished as a consequence of care (e.g., complications, readmissions, unplanned care, and emergency department visits). Unrelated services are not assigned to the episode. For example, the cost of care for a chronic condition that occurs during the episode but is not related to the clinical management of the patient relative to the breast cancer screening would not be assigned.

To ensure that only clinically related services are included, services during the episode window are assigned to the episode based on a series of service assignment rules, which are listed in the "Service_Assignment" tab of the Breast Cancer Screening Cost Measure Codes List file.

For the Breast Cancer Screening episode group, only services performed in the following service categories are considered for assignment to the episode costs:

- Basic diagnostic services:
    - Mammography; diagnostic ultrasound; breast biopsy; magnetic resonance imaging (MRI); E/M services (encounter for screening mammogram)
- Advanced diagnostic services:
    - Pathology (including surgical pathology); genetic testing; computed tomography/positron emission tomography (CT/PET) staging
- Treatment services:
    - Lumpectomy, quadrantectomy of breast; mastectomy; therapeutic radiology; cancer chemotherapy; anesthesia; laboratory (chemistry and hematology); non-

[9] In cases when multiple entities (professional component [modifier code 26] and technical/facility component [modifier code TC]) bill for the same patient on the same day, both entities are attributed.

hospital-based care; ancillary services; medications (injections, infusions, and other forms); durable medical equipment and supplies; hospitalizations (malignant breast disorders; septicemia or severe sepsis); complications of treatment (including hemorrhage); E/M (breast cancer diagnosis); cryoablation

In addition to service category, service assignment rules may be modified based on the service category in which the service is performed, as listed above. Service assignment rules may also be defined based on specific (i) service information alone or service information combined with diagnosis information, (ii) prior incidence of service, and/or (iii) the timing of the service, as detailed below.

- Services may be assigned to the episode based on the following service information combinations:
    - High level service code as defined by aggregated code categories (CCS and DRG)
    - High level service code combined with first 3 digits of the International Classification of Diseases – 10th Revision diagnosis code (3-digit ICD-10 diagnosis code)
    - High level service code combined with full ICD-10 diagnosis code
    - High level service code combined with more specific service code
    - High level service code combined with more specific service code and with 3-digit ICD-10 diagnosis code
    - High level service code combined with more specific service code and with full ICD-10 diagnosis code
- Services as defined by the applicable combinations and incidence options above may be assigned with only specific timing:
    - Services may be assigned only if they occur within a particular number of days from the trigger within the episode window, and services may be assigned for a period shorter than the full duration of the episode window.

The steps for assigning costs are as follows:

- **Identify** all services on claims with positive standardized payment that occur within the episode window.
- **Assign** identified services to the episode based on the types of clinically relevant service assignment rules described above.
- **Assign** all claims with trigger codes occurring during the triggering event (i.e., screening mammogram codes).
- **Assign** all IP E/M claims during IP stays in the post-trigger window assigned to episode if applicable.
- **Do not assign** the costs of advanced diagnostic services or costs of breast cancer treatment services to episodes with a breast cancer detection in the first 8 months after the trigger claim (early breast cancer detection episodes). This service assignment rule was established to ensure that the cost measure is intended to support and reward timely/early breast cancer detection. See Service_Assignment tab in the Cost Measure Codes List for more details.
- **Sum** standardized Medicare allowed amounts for all claims assigned to each episode to obtain the standardized total observed episode cost.

Service Assignment Example: Breast Cancer Screening with No Cancer Detection

- Clinician A performs a breast cancer screening mammogram for Patient K. This service triggers a Breast Cancer Screening Mammogram episode, which is attributed to Clinician A.
- Given an abnormal mammogram result, additional imaging is requested. Clinician B performs a breast MRI, which is considered a clinically related service, during the episode window.
- Because a breast MRI during the episode window is considered to be clinically related to the initial breast cancer screening mammogram, the cost of the MRI will be assigned to Clinician A's Breast Cancer Screening Mammogram episode.

Service Assignment Example: Breast Cancer Screening with Late Cancer Detection

- Clinician C performs a breast cancer screening mammogram for Patient J. This service triggers a Breast Cancer Screening Mammogram episode, which is attributed to Clinician C.
- The mammogram result is "normal."
- Nine months later, Patient J is diagnosed with breast cancer, and begins chemotherapy. Breast Cancer treatment services such as physician visits, additional imagining, genetic testing and chemotherapy services are included in the episode as this is late cancer detection.

## 4.4 Exclude Episodes

Before measure calculation, episode exclusions are applied to remove certain episodes from measure score calculation. Certain exclusions are applied across all episode groups, and other exclusions are specific to this measure, based on consideration of the clinical characteristics of a homogenous patient cohort. The measure-specific exclusions are listed in the "Exclusions" and "Exclusions_Details" tabs in the Breast Cancer Screening Cost Measure Codes List file.

The steps for episode exclusion are as follows:

- **Exclude** episodes from measure calculation if:
  - The patient was not found in MBSF.
  - Patient resides outside of the United States or its territories.
  - The patient's date of birth is missing.
  - The patient was not continuously enrolled in Medicare Parts A and B for the entirety of the lookback period plus episode window, or was enrolled in Part C for any part of the lookback plus episode window.
  - The patient's death date occurred during the episode.
  - The patient has extremely low costs.
- **Apply** measure-specific exclusions, which check the patient's Medicare claims history for certain billing codes (as specified in the Cost Measure Codes List file) that indicate the presence of a particular procedure, condition, or characteristic.

## 4.5 Estimate Expected Costs through Risk Adjustment

Risk adjustment is used to estimate expected episode costs in recognition of the different levels of care patients may require due to comorbidities, disability, age, and other risk factors. The risk adjustment model includes variables from the CMS Hierarchical Condition Category Version 24 (CMS-HCC V24) 2021 Risk Adjustment Model,[10] as well as other standard risk adjustors (e.g., patient age) and variables for clinical factors that may be outside the attributed clinician's

[10] The Centers for Medicare and Medicaid Services (CMS) uses an HCC risk adjustment model to calculate risk scores. The HCC model ranks diagnoses into categories that represent conditions with similar cost patterns. Higher categories represent higher predicted healthcare costs, resulting in higher risk scores.

reasonable influence. A full list of risk adjustment variables can be found in the “RA” and “RA_Details” tabs of the Breast Cancer Screening Cost Measure Codes List file.

Steps for defining risk adjustment variables and estimating the risk adjustment model are as follows:

- **Define** HCC and episode group-specific risk adjustors using service and diagnosis information found on the patient’s Medicare claims history in the 365-day period prior to the episode trigger day (or the timing specified in the "RA_Details" tab of the Cost Measure Codes List file) for certain billing codes that indicate the presence of a procedure, condition, or characteristic.
- **Define** other risk adjustors that rely upon Medicare beneficiary enrollment and assessment data as follows:
    - Identify patients who are originally “Disabled without ESRD” or “Disabled with ESRD” using the original reason for joining Medicare field in the Medicare beneficiary EDB.
- **Drop** risk adjustors that are defined for less than 15 episodes nationally for each sub-group to avoid using very small samples.
- **Categorize** patients into age ranges using their date of birth information in the Medicare beneficiary EDB. If an age range has a cell count less than 15, collapse this in the next adjacent age range category towards the reference category (65-69).
- **Run** an ordinary least squares (OLS) regression model to estimate the relationship between all the risk adjustment variables and the dependent variable, the standardized observed episode cost, to obtain the risk-adjusted expected episode cost. A separate OLS regression is run for each episode sub-group nationally.
- **Exclude**[11] episodes with outliers as follows. This step is performed separately for episodes without cancer detection, episodes with early detection, and episodes with late detection.
    - Calculate each episode's residual as the difference between the expected cost computed above and the observed cost.
    - Identify outlier thresholds separately for episodes without cancer detection, episodes with early detection, and episodes with late detection. Exclude episodes with residuals below the 1$^{st}$ percentile or above the 99$^{th}$ percentile of the residual distribution for each episode category.
    - Renormalize the resultant expected cost values by multiplying each episode’s expected costs after excluding outliers by the sub-group's average standardized observed cost after excluding outliers, and dividing by the sub-group's average expected cost after excluding outliers.

## 4.6 Calculate Measure Scores

Measure scores are calculated for a TIN or TIN-NPI as follows:

- Calculate the ratio of observed to expected episode cost for each episode attributed to the clinician/clinician group.
- Calculate the average ratio of observed to expected episode cost across the total number of episodes attributed to the clinician/clinician group.

[11] This step excludes episodes based on outlier residual values from the calculation and renormalizes the resultant values to maintain a consistent average episode cost level.

- Multiply the average ratio of observed to expected episode cost by the national average observed episode cost to generate a dollar figure representing risk-adjusted average episode cost.

The clinician-level or clinician group practice-level risk-adjusted cost for any attributed clinician (or clinician group practice) "j" can be represented mathematically as:

$$Measure\ Score_j = \left(\frac{1}{n_j}\sum_{i \in I_j}\frac{Y_{ij}}{\widehat{Y_{ij}}}\right)\left(\frac{1}{n}\sum_{j}\sum_{i \in \{I_j\}} Y_{ij}\right)$$

where:

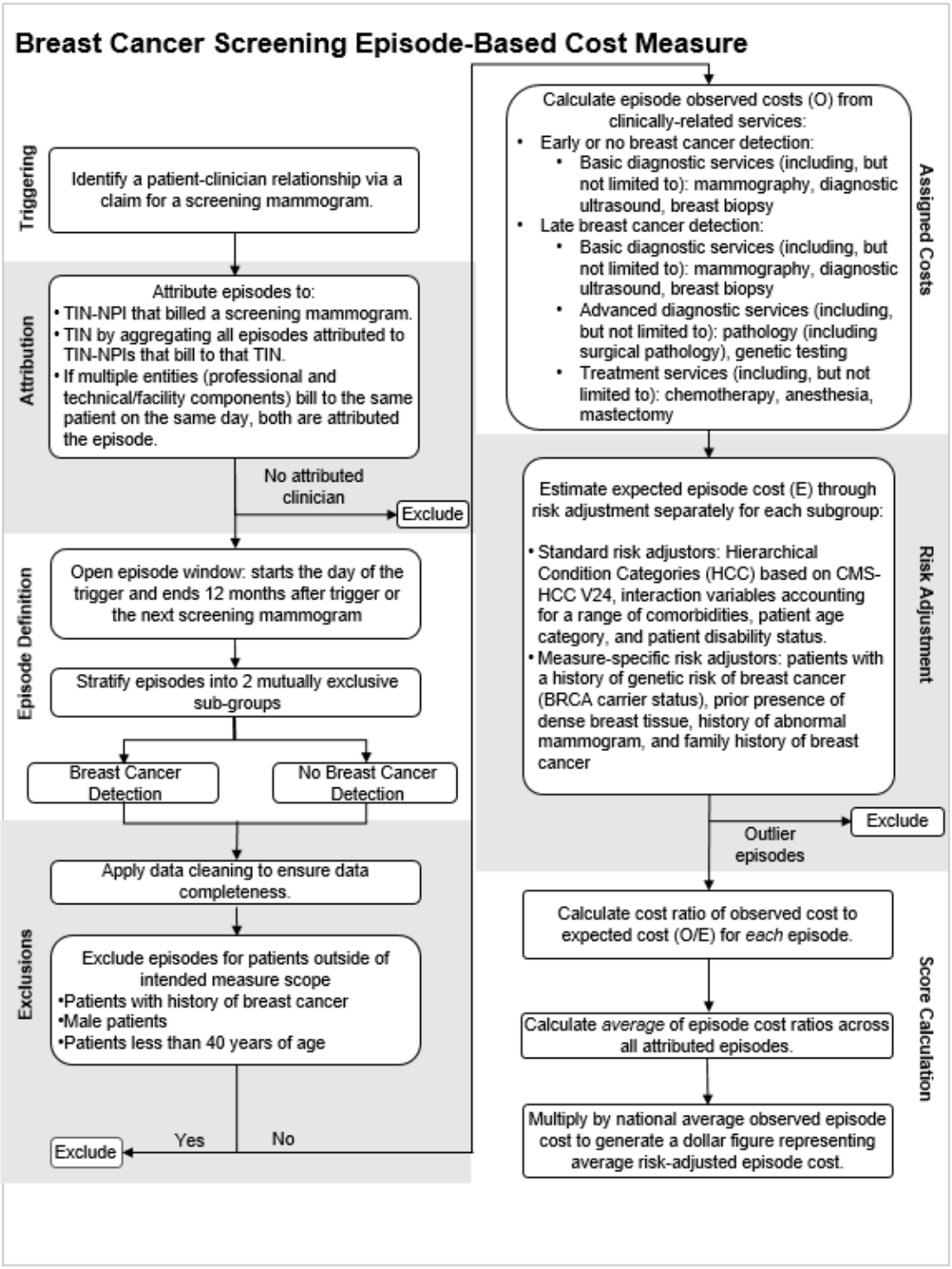
| | |
|---|---|
| $Y_{ij}$ | is the standardized payment for episode *i* and attributed clinician (or clinician group practice) *j* |
| $\hat{Y}_{ij}$ | is the expected standardized payment for episode *i* and clinician (or clinician group practice) *j*, as predicted from risk adjustment |
| $n_j$ | is the number of episodes for clinician (or clinician group practice) *j* |
| $n$ | is the total number of TIN/TIN-NPI attributed episodes nationally |
| $i \epsilon \{I_j\}$ | is all episodes *i* in the set of episodes attributed to clinician (or clinician group practice) *j* |

A lower measure score indicates that the observed episode costs are lower than or similar to expected costs for the care provided for the particular patients and episodes included in the calculation, whereas a higher measure score indicates that the observed episode costs are higher than expected for the care provided for the particular patients and episodes included in the calculation.

# Appendix A. Measure Flowchart

The diagram below provides an illustrated flowchart of the Breast Cancer Screening episode-based cost measure.

**Figure A-1. Breast Cancer Screening Episode-Based Cost Measure Flowchart**



# Appendix B. Measure Calculation Example

The diagram below provides an illustrated example of measure calculation, using an example measure where the clinician has only 4 attributed episodes for demonstration purposes.

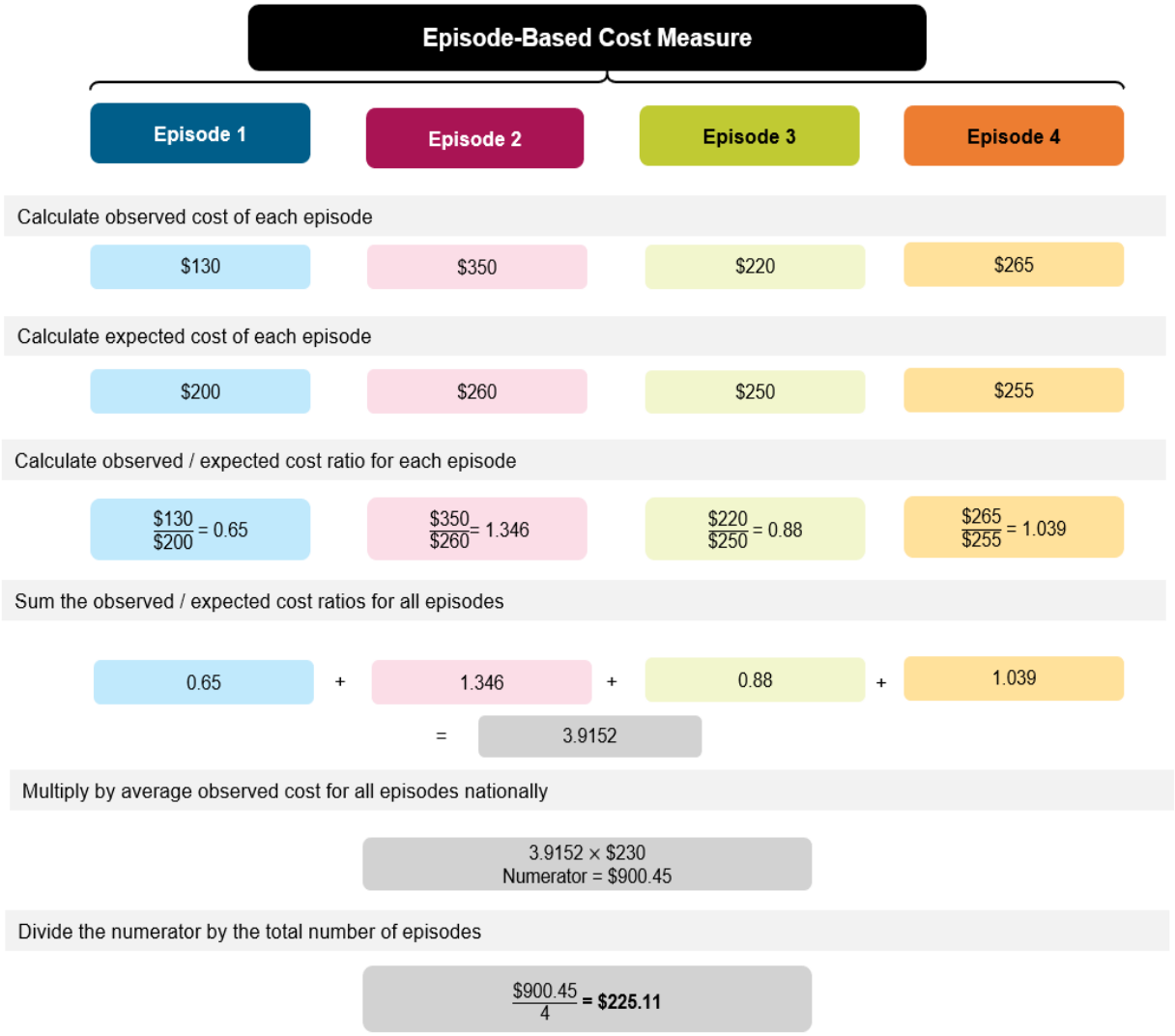



**Figure B-1. Breast Cancer Screening Episode-Based Cost Measure Calculation Example**