



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

PARKINSON'S SYNDROMES, MULTIPLE SCLEROSIS (MS), and AMYOTROPHIC LATERAL SCLEROSIS (ALS)

Overview

Measure Concept

- Parkinson's Syndromes, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) affect nearly half a million of Medicare beneficiaries
- Costs of management are significant for the patient and for Medicare (e.g., high rates of ED admissions, SNF stays, inpatient stays, and home health use)
- Neurodegenerative conditions are a current MIPS gap, greatly impact quality of life, and lead to poor health outcomes (e.g., falls, cognitive impairment)
- Measure aligns with several MIPS quality measures, supports CMS in assessing the overall value of care, and has low reporting burden for clinicians

Development & Input

- Clinical expert workgroup provided detailed input on all aspects of measure over 18 months
 - ✓ 15 members representing 18 professional societies
 - ✓ Member specialties include physical medicine and rehabilitation, internal medicine, family medicine, psychiatry, PT, OT, radiology, speech pathologist
- Nation-wide field testing/public comment opportunity in February 2024 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 for management and treatment of Parkinson's and related conditions, MS, or ALS across all patients/episodes during a performance period
- *Only* includes costs *clinically related* to Parkinson's and related conditions, MS, or ALS care
- Costs are *risk adjusted*, which allows fairer comparisons and accounts for differences in patient cohorts (e.g., comorbid health conditions, frailty, history of falling, cognitive status impairment, disease type, practice location)
- Measure calculated as comparison (ratio) of observed costs to expected costs, across all attributed episodes
 - ✓ Observed costs are *actual* payment-standardized costs for treatment
 - ✓ 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 clinicians' observed costs were lower than expected

Top 5 Specialties



1. Neurology
2. Nurse Practitioner
3. Physician Assistant
4. Internal Medicine
5. Physical Medicine and Rehabilitation

Measure Importance & Impact

Evaluates care provided across many patients & clinicians



395,078
episodes



283,806
patients



2,930 clinicians
(20-episode testing threshold)



2,930 groups

Covers large amount of Medicare costs



\$2.48 billion

(Group-level, 20-episode testing threshold)

Opportunities for Improvement

Examples of Included service Costs:	Routine provider visits, nutrition services, gastrointestinal services, behavioral health services	Medications, infusion therapy, deep brain stimulation	Fall-related services (fractures and joint replacements, subdural hematomas, etc.)	Emergency department visits, inpatient hospitalizations
Potential Improvement Opportunities:	<ul style="list-style-type: none">• Screen/monitor patients for comorbidities not related to physical complications• Manage comorbidities (e.g., cognitive impairment, mental/behavioral health interventions) to improve quality of life	<ul style="list-style-type: none">• Appropriate use of treatment options in consideration of clinical practice guidelines (CPG) and patient response	<ul style="list-style-type: none">• Improved patient education (fall prevention, physical activity) may prevent additional ED visits and hospitalizations and help mitigate the disease progression• Use PT/OT to maintain functional abilities and safe independence at home• Mitigate drug interactions/monitor for inappropriate medications that may cause severe adverse drug reactions	



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/medicare-coverage-analyses/mcas.aspx).



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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 clinician improvements

- ✓ 90th percentile is more than double the 10th percentile score for groups and individual clinicians
- ✓ Strong variation in clinician performance, and therefore, opportunity for improvement

		Distribution Across Percentiles					
		Level	10 th	25 th	50 th	75 th	90 th
Average Risk Adjusted Cost							
Groups	\$14,646	TIN	\$9,897	\$12,037	\$14,276	\$16,695	\$19,665
Individual Clinicians	\$14,425	TIN-NPI	\$9,168	\$11,140	\$13,840	\$16,871	\$20,537

Validity | accuracy in measuring what we intend



Results show the measure assesses the intended costs, which include routine treatment and management plus the added costs of potentially avoidable costs related to complications and worsening of symptoms. As expected, episodes with adverse events have higher risk adjusted costs.

Compared to the average risk adjusted episode (\$14,565):



Episodes with clinically-related **hospitalizations** have **2.5x higher** risk adjusted episode costs (\$37,769)



Episodes with **emergency department visits** have **40% higher** risk adjusted episode costs (\$20,614)

Social Risk Factor (SRF) Testing | evaluating appropriateness for risk adjustment

SRF testing helps evaluate the balance between wanting to ensure fairness for clinicians treating higher shares of vulnerable patients and preventing masking poor clinician performance that disadvantages patients. There are many possible variables to use when testing and adjusting for SRFs such as whether a person is dually enrolled in Medicare and Medicaid.

- ✓ Testing confirmed that using dual enrollment in Medicare and Medicaid in risk adjustment more consistently predicts episode spending than other social risk factors, like race/ethnicity or community-level socioeconomic status variables.

This measure adjusts for episodes where patients have dual enrollment status because...

- ✓ Without risk adjusting for dual status, most clinicians perform equally well on dual and non-dual episodes (91%), but more clinicians perform significantly worse on dual episodes (9%) than perform significantly better (0.2%)
- ✓ Most clinicians see their scores shift by less than 5 percentiles after adjusting for dual status (90%), but 10% have scores that shift by 5 percentiles or more

Reliability | consistency in repeat measurements

At a 20 episode testing threshold, the mean reliability is **moderate**. This measure assesses meaningful differences in clinician performance.

Groups 0.61

Individual Clinicians 0.57



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