



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

## NON-PRESSURE ULCERS

### Overview

#### Measure Concept

- Chronic ulcers are highly prevalent in older adults
  - 15-25% of diabetes patients develop foot ulcers
  - Venous ulcers affect 5% of older adults
- Ulcers greatly impact quality of life and lead to poor health outcomes, loss of function, and amputation
- Measure aligns with several MIPS quality measures, supports CMS in assessing the overall value of care, and has low reporting burden for clinicians
- Captures podiatrists, who do not currently have an applicable an episode-based cost measure

#### Development & Input

- Clinical expert workgroup provided detailed input on all aspects of measure over 12 months
  - ✓ 19 members representing 14 professional societies
  - ✓ Member specialties include podiatry, wound care specialists, critical care, family medicine, vascular surgery, PT, OT, radiology, dermatology
- Nation-wide field testing/public comment opportunity in January and February 2026 to gather 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 non-pressure ulcer care across all patients/episodes during a performance period
- Only* includes costs *clinically related* to ulcer care
- Costs are *risk adjusted*, which allows fairer comparisons and accounts for differences in patient cohorts (e.g., comorbid health conditions including diabetes, lymphedema, smoking, frailty, ulcer 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

- Podiatry
- Nurse Practitioners
- Family Practice
- General Surgery
- Internal Medicine



#### Measure Importance & Impact

Evaluates care provided across many patients & clinicians



**361,333**  
episodes



**293,342**  
patients

(20-episode testing threshold)



**3,809** clinicians



**3,730** groups

#### Opportunities for Improvement

Examples of Included Service Costs	Wound debridement services	Durable medical equipment and supplies (wound care products, orthotic devices, etc.)	Inpatient hospitalization (infection/ cellulitis, amputation, etc.)	Advanced wound care treatments, hyperbaric oxygen therapy (HBOT)
Potential Improvement Opportunities	<ul style="list-style-type: none"><li>Provide as needed for venous ulcers</li><li>Limit wound debridement and compression therapy per Clinical Practice Guidelines (CPGs) for arterial ulcers</li></ul>	<ul style="list-style-type: none"><li>Offloading treatments (e.g., total contact casting, removable cast walkers, forefoot casting) for appropriate periods of time for diabetic ulcers</li><li>Use of compression systems (e.g., multi-component bandage) for venous ulcers</li></ul>	<ul style="list-style-type: none"><li>Improved patient education on wound care and infection prevention may reduce complications</li><li>Frequent diabetic ulcers evaluation to assess for infection and response to treatment</li></ul>	<ul style="list-style-type: none"><li>Consider advanced therapies for higher stage diabetic ulcers (e.g., negative pressure wound therapy, extracellular matrix products, HBOT)</li><li>Follow CPGs for determining appropriate use across ulcer types</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](#).



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## Testing and Acceptability

### Performance Gap & Improvement Opportunity | sufficient variation

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

- ✓ 90<sup>th</sup> percentile is more than triple the 10<sup>th</sup> percentile score for groups and clinicians
- ✓ Strong 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	\$4,363	Group	\$2,219	\$2,909	\$3,854	\$5,201	\$7,066
Clinicians	\$3,998	Clinician	\$1,835	\$2,502	\$3,479	\$4,801	\$6,692

### 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 cost (\$3,783):



Episodes with **major procedures**, like amputations, have **more than 3x higher** risk adjusted episode costs (\$12,551)



Episodes with clinically-related **inpatient hospitalizations** have **nearly 5x higher** risk adjusted episode costs (\$17,510)

### 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.

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 (89%), but more clinicians and groups perform significantly worse on their dual episodes (about 7-8%) than perform significantly better (2%).
- ✓ Many clinicians and groups (40%) see their scores shift by 1 percentile or more after adjusting for dual status.

The measure does not adjust for provider location, as performance is similar in rural and urban locations for groups (average rural risk adjusted cost: \$4,179, average urban risk adjusted cost: \$4,398) and clinicians (average rural risk adjusted cost: \$3,821, average urban risk adjusted cost: \$4,028).

### Reliability | consistency in repeat measurements

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

**Groups 0.85**

**Individual Clinicians 0.83**



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](#) for full details and additional results.