



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

## PARKINSONISM SYNDROMES AND MULTIPLE SCLEROSIS (MS)

### Overview

#### Measure Concept

- Parkinsonism Syndromes and Multiple Sclerosis (MS) 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

#### Continued Development & Input

- Clinical expert workgroup provided detailed input on all aspects of the measure over 12 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 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 management and treatment of Parkinson's and related conditions or MS across all patients/episodes during a performance period
- *Only* includes costs *clinically related* to Parkinson's and related conditions or MS 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 clinician's 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



**437,716**  
episodes



**294,337**  
patients

(20-episode testing threshold)



**2,884** clinicians



**3,115** groups

### Opportunities for Improvement

Examples of Included service Costs:	Routine provider visits, nutrition services, gastrointestinal services, behavioral health services	Medications, infusion therapy	Fall-related services (fractures and joint replacements, subdural hematomas, etc.)	Emergency department visits, inpatient hospitalizations
Potential Improvement Opportunities:	<ul style="list-style-type: none"> <li>• Screen/monitor patients for comorbidities not related to physical complications</li> <li>• Manage comorbidities (e.g., cognitive impairment, mental/behavioral health interventions) to improve quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• Appropriate use of treatment options in consideration of clinical practice guidelines (CPG) and patient response</li> </ul>	<ul style="list-style-type: none"> <li>• Improved patient education (fall prevention, physical activity) may prevent additional ED visits and hospitalizations and help mitigate the disease progression</li> <li>• Use PT/OT to maintain functional abilities and safe independence at home</li> <li>• Mitigate drug interactions/monitor for inappropriate medications that may cause severe adverse drug reactions</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?blogcategory=10).



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### Testing and Acceptability

#### Performance Gap & Improvement Opportunity | sufficient variation

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

- ✓ 90<sup>th</sup> percentile is more than double 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>
Groups	Average Risk Adjusted Cost \$14,064	Group	\$9,416	\$11,529	\$13,685	\$16,002	\$18,850
Clinicians	\$13,944	Clinician	\$8,528	\$10,623	\$13,268	\$16,368	\$20,015

#### 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 (\$14,017):



Episodes with clinically-related **hospitalizations** have **2.5x higher** risk adjusted episode costs (\$37,788)



Episodes with **emergency department visits** have **40% higher** risk adjusted episode costs (\$21,053)

#### 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 (90%), but more clinicians perform significantly worse on dual episodes (9%) than perform significantly better (0.7%).
- ✓ Most clinicians see their scores shift by less than 5 percentiles after adjusting for dual status (91%), but 9% have scores that shift by 5 percentiles or more.

The measure does not adjust for provider location, as performance is similar in rural and urban locations for groups (average rural risk adjusted cost: \$13,395, average urban risk adjusted cost: \$14,162) and clinicians (average rural risk adjusted cost: \$12,964, average urban risk adjusted cost: \$14,028).

#### 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 0.66**

**Clinicians 0.60**



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](https://www.cms.gov/medicare/coverage/informational/cost-measures-information) for full details and additional results.