

Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) Cost Measure Field Test Report

<<Provider Name>>

Taxpayer Identification Number (TIN): <<TIN #>>

Measurement Period: January 1, 2022 – December 31, 2022

1 MEASURE SCORE

This report shows your performance on the Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis (MS), and Amyotrophic Lateral Sclerosis (ALS) (Movement Disorders) measure for field testing. Field testing is a chance for stakeholders to provide feedback on the cost measures being developed in 2023-2024. For more information about field testing, please refer to the [CMS.gov QPP Cost Measure Information Page](#).¹

The field testing period is from **February 1 to February 29, 2024**. To provide feedback on this measure, please navigate to the [CMS.gov QPP Cost Measure Information Page](#).²

Contents

Movement Disorders Cost Measure Field Test Report	1
1 Measure Score.....	1
What is the Movement Disorders Cost Measure?.....	3
Your Field Testing Cost Measure Score	3
Histogram of National Cost Measure Scores	4
2 Breakdown of Cost Measure Performance	5
Episode Sub-Groups.....	5
Utilization and Cost of Different Types of Services	6
Clinicians Contributing to Your Episode Costs.....	9
3 Episode Costs	10
Your Risk-Adjusted Episode Costs	10
Histogram of National Risk-Adjusted Episode Costs	10
Episode-Level File (CSV).....	11
4 Additional Information	11
Where Can I Find More Information?	11
Appendix A – Glossary.....	12

The information in this report is for field testing only. It doesn't affect any scoring or payment adjustments in the Merit-based Incentive Payment System (MIPS). The information in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including but not limited to circumstances in which an error is discovered. Only clinicians (identified by their unique Taxpayer Identification Number [TIN] and National Provider Identifier [NPI] combination, or

¹ CMS.gov QPP Cost Measure Information Page, <https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/current>.

² CMS.gov QPP Cost Measure Information Page, <https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/current>.

TIN-NPI) and clinician groups (identified by their TIN) with at least 20 episodes during the measurement period have received a field test report.³

³ Individuals using assistive technology may not be able to fully access information in this file. To request a fully accessible report, contact macra-cost-measures-info@acumenllc.com.

What is the Movement Disorders Cost Measure?

The Movement Disorders cost measure assesses a clinician's or clinician group's risk-adjusted and specialty-adjusted cost to Medicare for patients receiving medical care to manage and treat movement disorders.

This chronic condition measure includes the costs of services that are clinically related to the attributed clinician's role in managing care during a Movement Disorders episode. In this report, "cost" generally means the Medicare allowed amount.⁴ Costs are payment-standardized to facilitate comparisons of resource use. Payment standardization assigns a comparable allowed amount for the same service by removing geographic differences and payment adjustments from special Medicare programs, such as add-on payments for medical education.⁵

In addition, the actual episode costs are scaled to a one-year period to enable meaningful comparison of costs between episodes of different length. The episode observed cost is also risk-adjusted to ensure fair comparisons. Risk adjustment neutralizes the effects of risk factors deemed to be outside of a clinician's influence (e.g., pre-existing conditions, age, or indicators of clinical severity). Finally, the measure adjusts for cost variation across specialties and across TINs with varying specialty compositions.

For more details, please refer to the Draft Cost Measure Methodology and the Draft Measure Codes List file on the [CMS.gov QPP Cost Measure Information Page](#).⁶

Your Field Testing Cost Measure Score

Table 1 shows how you performed on this measure in field testing. The score represents your average risk-adjusted cost to Medicare across all of your episodes for the Movement Disorders measure and adjusted for your group's specialty composition. You can compare it to the national average score to see how you performed compared to all clinician groups with a least one Movement Disorders measure episode. This is an inverse measure, so a lower score indicates a lower cost.

⁴ The Medicare allowed amount on Medicare claims data includes both Medicare and trust fund payments and any applicable patient deductible and coinsurance amounts.

⁵ CMS, Price (Payment) Standardization Overview, <https://www.resdac.org/articles/cms-price-payment-standardization-overview>.

⁶ CMS.gov QPP Cost Measure Information Page, <https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/current>.

Table 1: Your Field Testing Cost Measure Score

	Movement Disorders Measure
Number of Episodes	--
Your Cost Measure Score (TIN)	\$--
National Average Cost Measure Score	\$ 14,666
Your Cost Measure Score Percentile (TIN)	--

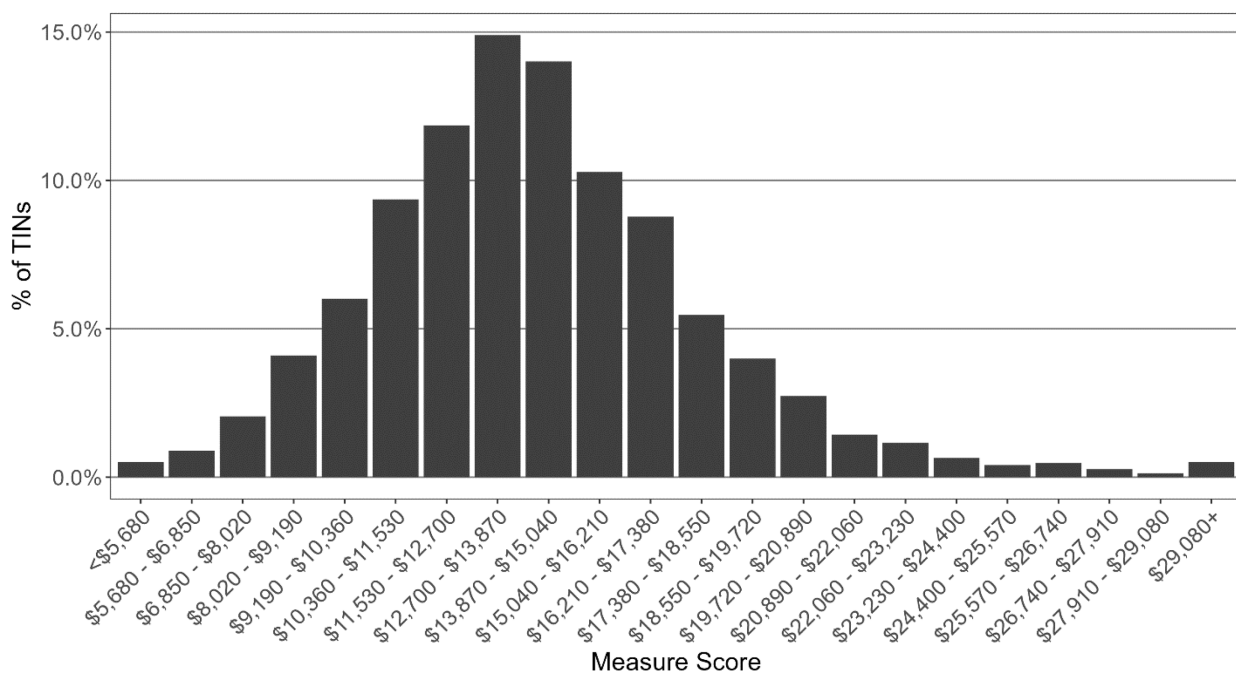
Note: Refer to the Glossary, [Table A1](#) for definitions of metrics

The score percentile shows where you rank among all clinician groups receiving a field test report. It represents the percentage of clinician groups that had an equal or lower risk-adjusted cost to Medicare. Since this is an inverse measure, a lower percentile means that you performed at a lower cost than more clinician groups. For example, if you're in the 25th score percentile, it means that your score was lower and you performed at a lower cost than 75% of clinician groups for this measure.

Histogram of National Cost Measure Scores

Figure 1 shows a histogram of how clinician groups performed on the Movement Disorders measure in field testing. Specifically, the distribution includes measure scores for all TINs with at least 20 Movement Disorders measure episodes.

Figure 1: National Distribution of Field Testing Measure Scores



2 BREAKDOWN OF COST MEASURE PERFORMANCE

There are many ways of looking at where costs are coming from in your measure. This section has information about types of services and clinicians who are contributing to your episode costs.

Episode Sub-Groups

Episode sub-groups are mutually exclusive and exhaustive stratifications of a cost measure, and they enable meaningful clinical comparisons. The sub-groups for this measure were developed based on clinical input from members of the Movements Disorders Clinician Expert Workgroup.⁷ Table 2 presents your count and share of episodes as well as your performance on the mean ratio of winsorized annualized observed to annualized expected cost by episode sub-group alongside the national average (i.e., across all clinician groups nationally).

Table 2: Cost Measure Performance by Episode Sub-Group

Episode Sub-Group	Your Episode Count	Share of Episodes		Mean Ratio of Winsorized Annualized Observed to Expected Cost	
		Your TIN	National Average	Your TIN	National Average
Movements Disorders	--	--	100.0%	--	1.09
Parkinson's and Related Disorders	--	--	72.2%	--	1.09
Multiple Sclerosis (MS)	--	--	26.8%	--	1.09
Amyotrophic Lateral Sclerosis (ALS)	--	--	1.0%	--	1.15

Refer to the Glossary, [Table A2](#) for definitions of metrics.

⁷ More detailed information on episode sub-groups can be found in the Draft Measure Methodology document and the Draft Measure Codes List, which are both available on the Cost Measures Information page. <https://www.cms.gov/medicare/quality/value-based-programs/cost-measures>

Utilization and Cost of Different Types of Services

This section shows what types of costs are being captured by the measure. Table 3 shows your performance compared with the national average and for TINs in your risk bracket. A risk bracket represents clinician groups likely to have a similar patient case-mix as you.

Risk brackets are constructed in several steps:

- We calculate a risk score for each episode that indicates the complexity of your patient.
 - It's calculated as the episode's expected cost (as predicted through risk adjustment) divided by the national average observed cost for the measure.
 - This yields a ratio, where a higher value indicates that the episode is expected to be more costly, based on the patient characteristics in the risk adjustment model.
- We then calculate your average risk score. This is the average of the risk scores for all your episodes.
- Finally, we create a distribution for the average risk score across all clinician groups with at least 20 episodes for this measure.
 - We divide the distribution into deciles to create risk brackets.
 - Each risk bracket has clinician groups who, on average, have a similar average episode risk score as you.

Table 3 provides a breakdown of service use and cost by setting and various categorizations. The table includes Medicare Parts A, B, and D services. For Part B and outpatient services, the table uses the Restructured BETOS Classification System (RBCS). This is a taxonomy that allows researchers to group Medicare Part B healthcare service codes into clinically meaningful categories.⁸

You can use this table to see how often your episodes have particular services, and compare this to the national average and to clinician groups with a similar case-mix. You can also see the average observed cost of those services for all episodes with at least one service in a particular category.

Table 3 highlights values where your performance is more markedly different from clinician groups in your risk bracket with:

- An asterisk (*), which indicates that your performance was more than 1 standard deviation above the average for clinician groups in your risk bracket; and
- A caret (^), which indicates that your performance was more than 2 standard deviations above the average for clinician groups in your risk bracket.

⁸ CMS, Restructured BETOS Classification System, <https://data.cms.gov/provider-summary-by-type-of-service/provider-service-classifications/restructured-betos-classification-system>.

Table 3: Service Use and Cost by Medicare Setting and Service Category

Medicare Setting and Service Category	Share of Episodes with ≥1 Service			Average Observed Cost of Services among Episodes with ≥ 1 Service		
	Your TIN	National Average	Your Risk Bracket	Your TIN	National Average	Your Risk Bracket
All Services	--	100.0%	--	\$--	\$13,762	\$--
Hospital Inpatient Services	--	33.7%	--	\$--	\$8,587	\$--
Inpatient Hospital	--	27.4%	--	\$--	\$11,444	\$--
Multiple Sclerosis and Cerebellar Ataxia	--	11.3%	--	\$--	\$8,770	\$--
Rehabilitation	--	13.2%	--	\$--	\$7,968	\$--
Degenerative Nervous System Disorders	--	13.9%	--	\$--	\$9,404	\$--
Fractures of Hip and Pelvis	--	8.0%	--	\$--	\$4,826	\$--
Hip Replacement with Principal Diagnosis of Hip Fracture	--	9.0%	--	\$--	\$13,020	\$--
Physician Services During Hospitalization	--	33.6%	--	\$--	\$955	\$--
Outpatient Services	--	100.0%	--	\$--	\$1,852	\$--
Evaluation and Management (E/M) Services	--	100.0%	--	\$--	\$1,126	\$--
Annual Wellness Visits	--	47.7%	--	\$--	\$121	\$--
Chronic and Transitional Care Management	--	30.6%	--	\$--	\$303	\$--
Physical, Occupational, or Speech Language Pathology Therapy	--	42.0%	--	\$--	\$2,081	\$--
PT/OT Evaluation	--	38.7%	--	\$--	\$156	\$--
PT Treatment	--	38.2%	--	\$--	\$1,986	\$--
Speech Therapy	--	19.1%	--	\$--	\$985	\$--
Occupational Therapy	--	24.9%	--	\$--	\$307	\$--
Ancillary Services	--	72.2%	--	\$--	\$978	\$--
Laboratory, Pathology, and Other Tests	--	63.7%	--	\$--	\$150	\$--
Imaging Services	--	38.8%	--	\$--	\$457	\$--
CT/CTA - Head and Neck	--	27.1%	--	\$--	\$229	\$--
Magnetic Resonance	--	29.5%	--	\$--	\$395	\$--
Durable Medical Equipment and Supplies	--	32.2%	--	\$--	\$3,053	\$--
Wheelchairs	--	23.9%	--	\$--	\$3,357	\$--
Oxygen and Supplies	--	9.5%	--	\$--	\$816	\$--
Hospital Beds	--	18.3%	--	\$--	\$426	\$--
Home Ventilator	--	13.2%	--	\$--	\$12,735	\$--
CPAP (Sleep Apnea)	--	9.1%	--	\$--	\$808	\$--
Emergency Department Services	--	42.9%	--	\$--	\$1,238	\$--

Medicare Setting and Service Category	Share of Episodes with ≥1 Service			Average Observed Cost of Services among Episodes with ≥ 1 Service		
	Your TIN	National Average	Your Risk Bracket	Your TIN	National Average	Your Risk Bracket
Evaluation and Management (E/M) Services	--	42.8%	--	\$--	\$1,159	\$--
Procedures	--	16.9%	--	\$--	\$145	\$--
Laboratory, Pathology, and Other Tests	--	26.6%	--	\$--	\$10	\$--
Imaging Services	--	35.9%	--	\$--	\$85	\$--
Post-Acute Care Services	--	55.6%	--	\$--	\$9,054	\$--
Home Health	--	47.5%	--	\$--	\$7,459	\$--
Skilled Nursing Facility	--	34.2%	--	\$--	\$8,642	\$--
Inpatient Rehabilitation or Long-Term Care Hospital	--	11.7%	--	\$--	\$22,906	\$--
Part D Services	--	79.0%	--	\$--	\$5,344	\$--
Anti-Parkinson's Drugs	--	64.2%	--	\$--	\$1,695	\$--
Urinary Antispasmodic	--	30.3%	--	\$--	\$1,207	\$--
ALS Agents	--	11.6%	--	\$--	\$11,883	\$--
Multiple Sclerosis Agents	--	38.0%	--	\$--	\$12,236	\$--
Muscle Relaxants	--	35.4%	--	\$--	\$199	\$--
Stimulants - Misc.	--	16.2%	--	\$--	\$489	\$--
All Other Services	--	83.1%	--	\$--	\$8,295	\$--
Ambulance Services	--	23.1%	--	\$--	\$549	\$--
Anesthesia Services	--	6.1%	--	\$--	\$35	\$--
Other Part B-Covered Drugs	--	36.1%	--	\$--	\$14,545	\$--
Injects and Infusions	--	35.6%	--	\$--	\$13,878	\$--
All Other Services Not Otherwise Classified	--	11.2%	--	\$--	\$1,670	\$--

Refer to the Glossary, [Table A3](#) for definitions of metrics.

Clinicians Contributing to Your Episode Costs

Table 4 lists the clinicians that contributed the most to your Part B Physician/Supplier episode costs for the Movement Disorders measure. The table is divided into columns for clinicians within and outside your TIN.

Table 4: Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs

NPIs Within Your TIN	NPIs Outside Your TIN
--	--
--	--
--	--
--	--
--	--

Refer to the Glossary, [Table A4](#) for definitions of metrics

3 EPISODE COSTS

Your measure score reflects how you performed on at least 20 episodes. This section shows episode cost distributions.

Your Risk-Adjusted Episode Costs

Table 5 shows how your risk-adjusted episode costs are spread out across the distribution.

Risk-adjusted costs are costs that have been calculated to take into account risk factors such as patient health characteristics, age, reason for enrollment, and others.

Table 5: Distribution of the Risk-Adjusted Costs for Your Episodes

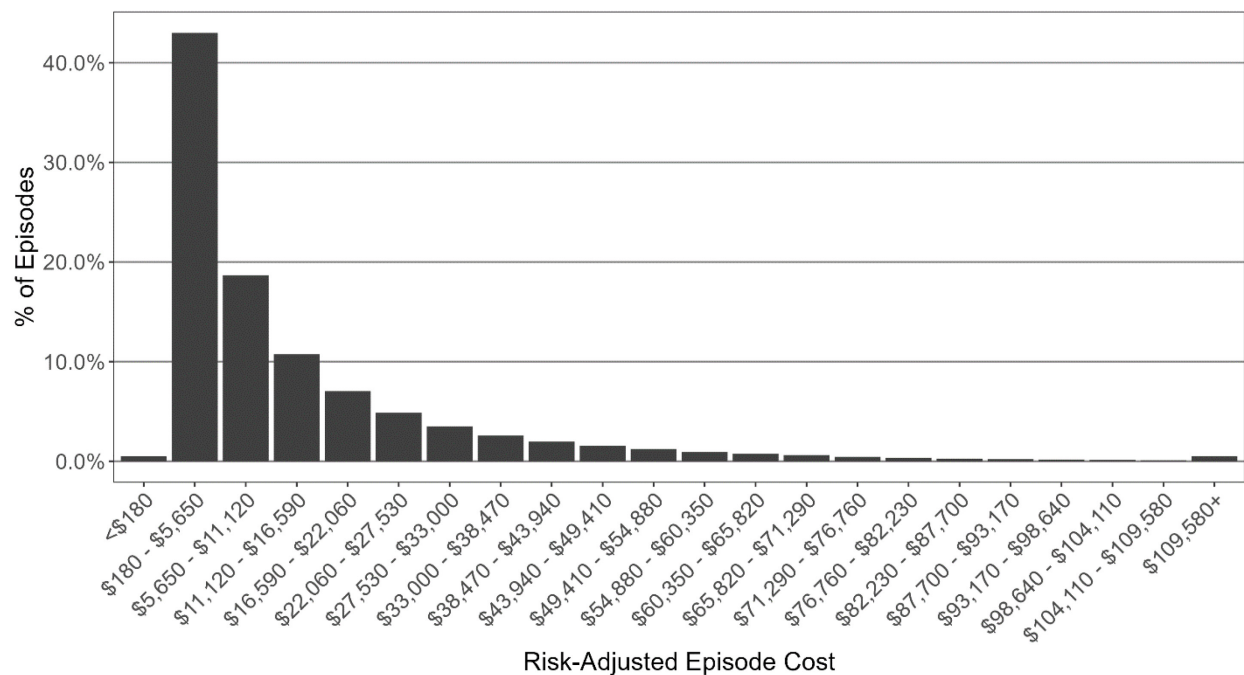
	Mean	Percentiles				
		5 th (Least Expensive)	25 th	50 th (Median)	75 th	95 th (Most Expensive)
Your Episodes	\$--	\$--	\$--	\$--	\$--	\$--

Refer to the Glossary, [Table A5](#) for definitions of metrics

Histogram of National Risk-Adjusted Episode Costs

Figure 2 shows a histogram of resource use for Movement Disorders measure episodes in field testing. Specifically, the distribution includes risk-adjusted episode costs for all episodes among clinician groups with at least 20 Movement Disorders measure episodes. Note that Figure 1 shows provider-level scores, whereas this figure shows episode-level costs.

Figure 2: National Distribution of Risk-Adjusted Episode Costs



Episode-Level File (CSV)

For the most granular information for each episode, you have an episode-level file in the same ZIP file as this report. This file lists each episode used to calculate your field testing measure score and provides information to help you understand the costs of care for each episode. It includes details to help you identify your patient and which providers furnished services during the episode of care. The file also has detailed breakdowns of what types of services in each episode counted towards your cost measure score. Finally, there's a data dictionary in the format of an Excel workbook that has definitions for all metrics in the episode-level file.

4 ADDITIONAL INFORMATION

Where Can I Find More Information?

The [CMS.gov QPP Cost Measure Information Page](#)⁹ has all the field testing resources. Materials include:

- Online field testing surveys (embedded in some of the field testing resources) where you can provide feedback about the measures,
- Frequently Asked Questions (FAQ),
- An overview of the measure development process,
- Draft measure specifications (Draft Cost Measure Methodology, Draft Measure Codes List file), and
- Testing results.

If you have further questions, please contact the Quality Payment Program Service Center:

- Email: gpp@cms.hhs.gov
- Telephone: 1-866-288-8292, Monday – Friday, 8 a.m. – 8 p.m. ET
 - To receive assistance more quickly, please consider calling during non-peak hours – before 10 a.m. and after 2 p.m. ET.
 - Customers who are hearing impaired can dial 711 to be connected to a Telecommunications Relay Services Communications Assistant.

⁹ CMS.gov QPP Cost Measure Information Page, <https://www.cms.gov/medicare/quality/value-based-programs/cost-measures/current>.

Appendix A – Glossary

Table A1: Definitions for Your Cost Measure Score Performance (Report: [Table 1](#))

Term	Description
Number of Episodes	The number of episodes attributed to your TIN within the measurement period.
Your TIN's Cost Measure Score	<p>Your TIN's average risk-adjusted cost for the measure.</p> <p><u>Method of calculation:</u> The weighted average ratio of the observed cost to expected cost (as predicted through a risk adjustment model) across all your episodes, multiplied by the national average observed episode cost. The weighting factor for each episode's number of assigned days.</p>
National Average Cost Measure Score	<p>Average risk-adjusted cost across all clinician groups nationally for this episode-based cost measure.</p> <p><u>Method of calculation:</u> The mean ratio of observed cost to expected cost (as predicted through a risk adjustment model) across all clinician groups nationally, multiplied by the national average observed episode cost. The mean ratio is calculated by taking the weighted average of the observed to expected ratio for each clinician group (the weighting factor for each episode's number of assigned days) and then calculating the average of these ratios across all clinician groups.</p>
Your TIN's Cost Measure Score Percentile	<p>The percentile for your TIN's cost measure score among all cost measure scores for all clinician groups nationally.</p> <p><u>Interpretation:</u> Higher values indicate that your episodes are relatively more expensive than episodes attributed to other clinician groups (and the inverse for lower values).</p> <p><u>Example:</u> If your cost measure score percentile is in the 40th percentile, then that means your cost measure score was higher than the scores for 40% of all clinician groups nationally and lower than the scores for 60% of all clinician groups. This is an inverse measure, so a lower score indicates a lower cost.</p>

Table A2: Definitions for Your Cost Measure Score Performance (Report: [Table 2](#))

Term	Description
Episode Sub-Group	The name of the measure or the episode sub-group. Episode sub-groups are divisions, or stratifications, for a measure that define more homogenous patient cohorts to ensure clinical comparability (i.e., the cost measure fairly compares like patients).
Your Episode Count	The number of episodes attributed to your TIN within the measurement period for each sub-group (or the measure as a whole).
Share of Episodes	<u>Your TIN:</u> Share of episodes (across all episodes for your TIN) by sub-group. <u>National Average:</u> Average share of episodes (for all clinician groups nationally) by sub-group.
Mean Ratio of Winsorized Annualized Observed to Expected Cost	<u>Your TIN:</u> Your weighted average ratio of winsorized annualized standardized observed to annualized expected cost across your episodes for each sub-group (and for the measure as a whole). As a note, your cost measure score is the product of the weighted average ratio for the measure as a whole and the national average winsorized annualized observed episode cost, where the weighting is each episode's number of assigned days. <u>National Average:</u> The mean ratio of winsorized annualized standardized observed to annualized expected cost across all clinician groups nationally for each sub-group (and for the measure as a whole). This is calculated by taking the weighted average of the observed to expected ratio for each clinician group (the weighting is each episode's number of assigned days) and then calculating the average of these ratios across all clinician groups for each sub-group.

Table A3: Definitions for Cost and Use by Medicare Setting and Service Category
(Report: [Table 3](#))

Term	Description
Medicare Setting and Service Category	The settings and service categories available from the claims data. This includes RBCS categorizations.
Share of Episodes with ≥ 1 Service	<p><u>Your TIN</u>: The share of episodes with any cost from a setting/category across all episodes for your TIN.</p> <p><u>National Average</u>: The average share of episodes with any cost from a setting/category across all clinician groups nationally.</p> <p><u>TINs in Your Risk Bracket</u>: The share of episodes with any cost from a setting/category across all clinician groups in your risk bracket.</p>
Average Observed Cost of Services among Episodes with ≥ 1 Service	<p><u>Your TIN</u>: The average cost of services from a setting/category across all episodes for your TIN. Note that this average is calculated out of all your TIN's episodes that include at least 1 service from the given setting/category.</p> <p><u>National Average</u>: The average cost of services for a setting/category across all episodes for all clinician groups nationally. Note that this average is calculated out of all episodes that include at least 1 service from the given setting/category.</p> <p><u>TINs in Your Risk Bracket</u>: The average cost of services for a setting/category across all episodes for clinician groups in your risk bracket. Note that this average is calculated out of all episodes that include at least 1 service from the given setting/category.</p>

Table A4: Definitions for Top Clinicians Within and Outside Your TIN Contributing to Your Part B Physician/Supplier Episode Costs (Report: [Table 4](#))

Term	Description
NPIs Within Your TIN	List of the top 5 clinicians (i.e., NPIs) within your TIN that contributed the most Part B Physician/Supplier costs to your episodes.
NPIs Outside Your TIN	List of the top 5 clinicians (i.e., NPIs) outside your TIN that contributed the most Part B Physician/Supplier costs to your episodes.

Table A5: Distribution of the Risk-Adjusted Costs for Your Episodes (Report: [Table 5](#))

Term	Description
Risk-adjusted cost	This is the episode cost after accounting for risk factors deemed to be outside of a clinician group's influence (e.g., pre-existing conditions, age, or indicators of clinical severity). The episode cost is risk-adjusted to ensure fair comparisons and neutralize the effects of these risk factors. The distribution statistics of the risk-adjusted costs for your episodes are shown (including mean and various percentiles).