Quality Payment
PROGRAM

2026 Cost Measures Field Testing Survey: Questions for Field Testing Measure Specifications

Winter 2026 Field Testing

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2026 Cost Measures Field Testing Feedback Survey

1.0 Introduction

The Centers for Medicare & Medicaid Services (CMS) and Acumen, LLC are field testing three episode-based cost measures from January 29 to February 27, 2026. During this time, all interested parties can provide input on the draft measure specifications. **This survey will close at 11:59pm ET on February 27, 2026.**

The survey described below is available here: https://acumen.qualtrics.com/jfe/form/SV_bydizySYqslUifs, or you may submit a letter with your feedback (instructions below).

This survey is divided into two sections:

- Section 1: Measure-Specific Questions
- Section 2: Field Testing Questions

Comments will be considered as part of finalizing measure specifications. We estimate that it may take approximately 40 minutes to complete this survey.

- All questions are optional. You can answer as many questions in the survey as you like, or upload a comment letter (PDF or word).
- If you begin the survey and want to come back to it later, clicking "Exit Survey" will save your responses up to the previous page.

1.1 Background

Acumen, LLC is a measure development contractor working with CMS to develop episode-based cost measures for the Merit-based Incentive Payment System (MIPS). MIPS assess clinicians across four performance categories: quality, cost, Promoting Interoperability, and improvement activities. Performance category scores are combined into an overall MIPS score that determines payment adjustments in subsequent years.

Acumen has developed draft specifications for three episode-based cost measures for potential future use in MIPS covering a range of impactful clinical topics. The development process has incorporated input from expert panels, person and family engagement, and empirical analyses. These measures are now being field tested:

1. Breast Cancer Screening
2. Non-Pressure Ulcers
3. Parkinsonism Syndromes and Multiple Sclerosis (MS)

1.2 Field Testing Resources

Interested parties can review the following materials:

- Draft measure specifications
- Field testing FAQ
- Portal user access guide
- Field testing presentation recording
- Field test report walk through recordings
- Measure testing forms
- Measure at-a-glance documents

In addition, clinicians and groups that have the minimum number of episodes for a measure can access confidential Field Test Reports on the QPP webpage, which provide information about how they would have performed on the measure based on the draft specifications. If you did not receive a field test report, you can review a mock report available on the QPP.gov Cost Measure Information Page.

1.3 Commenter Details

1. Contact Information
   Name:
   Credentials:
   Professional Title:
   Email Address:

2. Are you completing this form as an individual or on behalf of an organization?

3. If you are a representative for an organization, please provide the full name of the organization and NOT abbreviations. (e.g., American Medical Association)

4. Would you like to submit your feedback in a PDF or Word document instead of completing the questions in this survey? If yes, please see Section 4.0 for guidance on uploading a comment letter.

2.0 Measure Specific Questions

We are interested in your feedback on the draft measure specifications for three episode-based cost measures:

- Breast Cancer Screening
- Non-Pressure Ulcers
- Parkinsonism Syndromes and Multiple Sclerosis (MS)

The draft measure specifications for each measure, comprising the draft Cost Measure Methodology document and the corresponding draft Measure Codes List file, are available on the QPP.gov Cost Measure Information Page.

Note: There is a separate list of questions specific to each measure. Feedback will be collected for one cost measure at a time. You can submit feedback for one or multiple measures.

1. Please indicate which cost measure(s) that you would like to submit feedback.

2.1 Breast Cancer Screening

This section lists questions specific to the Breast Cancer Screening Measure.

Question 1: Trigger Codes/Patient Cohort

Breast Cancer Screening episodes are triggered by a CPT/HCPCS code for a screening mammogram on Part B Physician/Supplier (Carrier) claims. Unlike chronic condition measures that require a confirming claim, this procedural measure uses a single trigger event—the screening mammogram—to open an episode. The trigger code identifies women 40 years of

age or older who received a screening mammogram, which serves as the starting point for the 360-day episode window.

Refer to the Draft Measure Codes List to see the specific codes used to trigger a Breast Cancer Screening episode ("Triggers" tab).

1. Does the trigger code appropriately identify a patient cohort that reflects the measure intent to assess costs to Medicare for women 40 years of age or older who received a screening mammogram? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale.

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).

Question 2: Attribution

Breast Cancer Screening episodes are attributed to the clinician (TIN-NPI) who bills the trigger code for the screening mammogram. Attribution occurs on the day of the trigger event. Groups (TINs) are attributed the aggregate of all episodes attributed to clinicians belonging to that TIN. If the same episode is attributed to more than one clinician within a TIN, the episode is only attributed once to that TIN.

The most frequently attributed clinician specialty is diagnostic radiology. Other clinicians captured by the measure include, but are not limited to, obstetricians and gynecologists (OB-GYNs), primary care practitioners, internal medicine physicians, and nurse practitioners, in situations where these clinicians bill sufficient screening mammographies to meet the testing case minimum (i.e., 10 episodes).

For a more detailed description of how we attribute episodes, please reference Section 4 of the Draft Measure Information Form (MIF).

2. Does the Breast Cancer Screening measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to breast cancer screening? If not, how could the measure better identify clinicians responsible for breast cancer screening-related care? Please explain your rationale.

Question 3: Sub-Grouping

The Breast Cancer Screening measure stratifies episodes into two mutually exclusive sub-groups based on whether breast cancer is detected during the 360-day episode window. Cancer detection is identified through claims indicating breast cancer treatment or two E/M services with a breast cancer diagnosis on separate days. Sub-grouping ensures clinicians are fairly compared against others with a similar patient case mix by running a separate risk adjustment regression for each sub-group. The sub-groups are:

- Breast Cancer Detection: characterized by breast cancer treatment or two E/M services with a breast cancer diagnosis on two separate days during the episode window

- No Breast Cancer Detection: characterized by no breast cancer treatment and fewer than two E/M services with a breast cancer diagnosis on distinct days during the episode window

Refer to the Draft Measure Codes List to see the codes used to create sub-groups for the measure ("Sub_Groups_Details" tab).

3. Is it reasonable to compare episodes with and without cancer detection separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Breast Cancer Screening episodes? Please explain your rationale.

Question 4: Service Assignment

The Breast Cancer Screening measure assigns clinically related services based on the stage of the screening-to-diagnosis pathway. Services are identified using CPT/HCPCS codes on Part B claims and MS-DRGs on Part A inpatient claims. The measure captures costs in the 12 months (360 days) following the initial screening mammogram, with different service categories assigned based on cancer detection timing:

Service Category	List of Clinically Related Services
Basic Diagnostic Services	Mammography; diagnostic ultrasound; breast biopsy; MRI; E/M services (encounter for screening mammogram)
Emergency Department (ED) Services	ED visits; critical care services
Advanced Diagnostic Services	Laboratory (chemistry and hematology); pathology; CT scan; radioisotope scan and function studies
Treatment Services	E/M services (with breast cancer diagnosis); breast biopsy, local excision, and other breast procedures; mastectomy; lumpectomy, quadrantectomy of breast; cancer chemotherapy; anesthesia; non-hospital based care; CT scan for radiation therapy; therapeutic radiology; therapeutic procedures (skin and breast, female organs); ancillary services; medications (injections, infusions, etc.); durable medical equipment and supplies; hospitalizations (malignant breast disorders; septicemia or severe sepsis; complications of treatment)

All Breast Cancer Screening episodes include the costs of basic diagnostic services and ED services. However, the measure only assigns the costs of advanced diagnostic services and a fixed oncology cost to late cancer detection episodes (i.e., when breast cancer is detected between 9-12 months of the screening mammogram).

Refer to the Draft Measure Codes List to see the specific services included in service assignment ("Service_Assignment_AB" tab).

4. Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for breast cancer screening? Please explain your rationale.

Question 5: Fixed Oncology Cost Methodology

For late cancer detection episodes (breast cancer detected between 9-12 months after the screening mammogram), the measure assigns a fixed treatment cost rather than actual treatment costs. This fixed cost is calculated as the median of episode-level treatment costs across all late cancer detection episodes captured during the performance period. Empirical testing demonstrates that approximately 92% of patients who are eventually diagnosed with breast cancer receive that diagnosis within 8 months of a screening mammogram.

This methodology ensures the measure incentivizes timely diagnosis and calls attention to potentially missed detection, without attributing costs of treatment services that may vary greatly due to factors outside the influence of the attributed clinician (such as cancer stage, patient treatment preferences, or oncologist decisions).

5. From a patient and quality-of-care perspective, what timeframe (e.g., within 8 months) would you consider appropriate for the majority of patients to begin receiving services related to their breast cancer diagnosis? What factors outside of an attributed clinician or group's control may impact this timing? Do you agree with assigning a fixed oncology cost (national median treatment cost) rather than actual treatment costs for late cancer detection episodes? Please explain your rationale.

Question 6: Risk Adjustment

The Breast Cancer Screening measure uses a robust risk adjustment model to account for patient-level factors outside the reasonable influence of the attributed clinician. The model includes standard risk adjustors from the CMS Hierarchical Condition Category (CMS-HCC) model: 86 HCC codes representing comorbidities, patient demographics (age), health status indicators (disability status, ESRD status, recent long-term care use), dual eligibility status, and types of clinician specialties from which the patient has received care.

Specific to the Breast Cancer Screening measure, additional risk adjustor variables include:

- History of genetic risk of breast cancer (BRCA carrier status)
- Prior presence of dense breast tissue
- History of abnormal mammogram
- Family history of breast cancer

These measure-specific risk adjustors were selected because they are present at the start of care, have a clinical relationship with expected costs, show variation in prevalence, are not indicators of care provided, are resistant to gaming, and are not redundant with other variables.

Refer to the Draft Measure Codes List to see more information on the standard and measure-specific risk adjustors for the measure ("RA" and "RA_Details" tabs).

6. Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment? Please explain your rationale.

Question 7: Exclusions

Exclusions remove patient populations where there is extreme cost variability not susceptible to performance improvement, or where the measure intent does not apply. The Breast Cancer Screening measure excludes the following patient cohorts:

- Male patients
- Patients under 40 years of age
- Patients with a history of breast cancer

Patients with a history of breast cancer are excluded because their subsequent mammograms would be considered diagnostic rather than screening, and their expected costs differ significantly from the general screening population.

7. Should there be any changes made to the current list of excluded episodes for the Breast Cancer Screening measure? Please explain your rationale.

Question 8: Quality Alignment

The intent is for the Breast Cancer Screening measure to be used in the MIPS Cost performance category. If added to MIPS in the future, it would be one part of the MIPS final score; the other performance categories are quality measures, improvement activities, and promoting interoperability.

8. Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Breast Cancer Screening measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.

Question 9: Actionability

A goal of episode-based cost measures is to provide clinicians with actionable information to improve patient care and cost efficiency.

9. Based on your understanding of the Breast Cancer Screening measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.

Question 10: Unintended Consequences

Episode-based cost measures are designed with multiple safeguards to minimize the risk of unintended consequences. Risk adjustment accounts for patient complexity so that clinicians are not penalized for treating higher-risk patients who may require more intensive or costly care. Service assignment ensures that only clinically related services within the clinician's reasonable influence are included in episode costs. Exclusions remove patient populations with extreme cost variability that is not susceptible to performance improvement. Sub-grouping ensures fair comparisons among clinicians with similar patient case mixes. Despite these safeguards, we want to ensure that the Breast Cancer Screening measure does not create incentives that could negatively impact patient care or access to services.

10. Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.

2.2 Non-Pressure Ulcers

This section lists questions specific to the Non-Pressure Ulcers measure.

Question 1: Trigger Codes / Patient Cohort

Non-Pressure Ulcers episodes require both a trigger claim and a confirming claim billed by the same group practice to establish a patient-clinician relationship and open an episode:

- **A trigger claim** marks the start of an episode. It is a Part B Physician/Supplier claim for a clinically relevant outpatient service (outpatient E/M or measure-specific E/M) paired with an ICD-10 diagnosis code indicating a non-pressure ulcer.
- **A confirming claim** indicates the continuation of a patient-clinician relationship. It is a second Part B Physician/Supplier claim using another outpatient E/M, measure-specific E/M, or any of the following confirming services paired with a non-pressure ulcer diagnosis: rehabilitation services, debridement, skin substitute procedures and products, wound dressing products, and wound modalities (e.g., vacuum assisted closure).

Note that the measure was refined to remove skin graft and flap procedures from confirming services during continued development. Workgroup members stated that flaps and grafts are not common indicators of ongoing treatment and management for non-pressure ulcers, and are often provided for reasons other than a non-pressure ulcers diagnosis.

Additionally, clinicians primarily providing physical and occupational therapy services can confirm a care relationship but not trigger one on their own, such that physical/occupational therapists may be attributed as part of a clinician group practice but not as individual clinicians.

Refer to the Draft Measure Codes List to see the specific codes used to trigger and confirm a Non-Pressure Ulcers episode ("Triggers_HCPCS" tab).

1. Do the trigger codes and confirming codes appropriately identify a patient cohort that reflects the measure intent to assess costs to Medicare for patients receiving treatment for non-pressure ulcers? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale. *[Open response text box]*

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).

Question 2: Attribution

Non-Pressure Ulcers episodes are attributed at both the group (TIN) and individual clinician (TIN-NPI) levels:

- **Group level attribution:** The episode is attributed to the group that billed the trigger and confirming claims.
- **Clinician level attribution:** Within the attributed group, the episode is attributed to individual clinicians who billed at least 30% of trigger or confirming codes on Part B Physician/Supplier claim lines during the episode. Clinicians must also have billed at least

one trigger or confirming code within 1 year prior to or on the episode start date to ensure attribution occurs after the clinician has met the patient.

The **trigger window**—the period during which the trigger and confirming claims must occur to establish a patient-clinician relationship—is 1 to 45 days. Specialty is not used to limit attribution; any clinician who meets the trigger and confirming requirements may be attributed episodes.

Note that during continued development, the trigger window was shortened from 1-180 days to 1-45 days to better reflect the typical treatment cycle for non-pressure ulcer patients and ensure the measure captures patients with active treatment relationships.

For a more detailed description of how we attribute episodes, please reference Section 4 of the Draft Measure Information Form (MIF).

2. Does the Non-Pressure Ulcers measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to non-pressure ulcer care? Does the trigger window length of 1-45 days appropriately identify a patient-clinician relationship given the typical treatment cycle for a non-pressure ulcer? Please explain your rationale.

Question 3: Episode Length

The episode window begins after the trigger window and represents the period during which cost outcomes are reasonably influenced by the attributed clinician. The minimum episode window is 90 days. If another trigger or confirming code is billed by the same group within the current 90-day window (i.e., a reaffirming claim), the episode extends by another 90 days to indicate an ongoing care relationship.

Costs include those billed by the attributed clinician as well as downstream costs billed by non-attributed clinicians, representing outcomes of the attributed provider's care (e.g., a related hospitalization).

Note that during continued development, the episode window was shortened from 365 days to 90 days to better reflect the typical treatment cycle for non-pressure ulcer patients and prevent newly occurring ulcers from being counted as outcomes of prior care rather than initiating a new episode.

3. Does the minimum episode length of 90 days (with extensions for reaffirming claims) appropriately capture the period during which attributed clinicians can reasonably influence the costs of non-pressure ulcer care? Please explain your rationale.

Question 4: Sub-Grouping

The Non-Pressure Ulcers measure stratifies episodes into five mutually exclusive sub-groups based on ulcer type. Ulcer type is identified using ulcer-specific diagnosis codes or general diagnosis codes (diabetic, arterial, venous) paired with non-specific ulcer codes during the 120-day lookback period including the episode start date. Sub-grouping ensures clinicians are fairly compared against others with a similar patient case mix by running a separate risk adjustment regression for each sub-group. The sub-groups are:

- **Diabetic Ulcer Type**: episodes with ulcer-specific diagnosis codes or general diabetic diagnosis codes paired with a non-specific ulcer code
- **Arterial Ulcer Type**: episodes with ulcer-specific diagnosis codes or general arterial diagnosis codes paired with a non-specific ulcer code
- **Venous Ulcer Type**: episodes with ulcer-specific diagnosis codes or general venous diagnosis codes paired with a non-specific ulcer code
- **Multiple Ulcer Types**: episodes with diagnosis codes indicating at least 2 different types of ulcers
- **Non-specific Ulcer Type**: episodes with only non-specific non-pressure ulcers diagnoses (i.e., L97/L98 ICD-10 codes)

Refer to the Draft Measure Codes List to see the codes used to create sub-groups for the measure ("Sub_Groups_Details" tab).

4. Is it reasonable to compare episodes according to ulcer type separately (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Non-Pressure Ulcers episodes? Please explain your rationale.

Question 5: Service Assignment

The Non-Pressure Ulcers measure assigns clinically related services that encompass variations in treatment options, intensity or duration of treatment, routine care and monitoring, acute exacerbations, complications, and supportive care. Services are identified using CPT/HCPCS codes on Part B claims, MS-DRGs (Medicare Severity Diagnosis Related Groups) on Part A inpatient claims, and NDC codes for Part D drugs. The measure currently includes the following service categories:

- Outpatient E/M services; rehabilitation services; diagnostic services (e.g., physical and occupational therapy, imaging, labs/pathology)
- Related inpatient hospital services (e.g., amputations, cellulitis, osteomyelitis, skin grafts, wound debridement, and other physician services during hospitalization)
- Major/minor procedures (e.g., skin procedures, joint injections, hyperbaric oxygen, vascular procedures)
- Post-acute care services
- Emergency department services
- Durable medical equipment and supplies (e.g., orthotic devices, compression supplies, and wound care dressings)
- Part B covered drugs (e.g., antibiotics)
- Part D services (i.e., antibiotics, wound care products, medical devices and supplies)

Amputations are assigned to the measure as follows:

- **Outpatient amputations**: identified by a relevant CPT/HCPCS code and a non-pressure ulcers diagnosis appearing on the claim
- **Inpatient amputations**: identified by the stay's MS-DRG and diagnoses appearing on the claim. The following MS-DRGs are currently included:
    - 239: Amputation for Circulatory System Disorders Except Upper Limb and Toe with a non-pressure ulcers diagnosis
    - 255: Upper Limb and Toe Amputation for Circulatory System Disorders with a non-pressure ulcers diagnosis
    - 616: Amputation of Lower Limb for Endocrine, Nutritional & Metabolic Disorders with a non-pressure ulcers diagnosis
    - 474: Amputation for Musculoskeletal System and Connective Tissue Disorders with a principal diagnosis of osteomyelitis

Refer to the Draft Measure Codes List to see the specific services included in service assignment ("Service_Assignment_AB" and "Service_Assignment_D" tabs).

5. Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for non-pressure ulcer care? Please explain your rationale. Should osteomyelitis-related amputations be assigned to the measure as a clinically related service? If so, should this service be identified as currently specified, or are there other codes that would more accurately identify this service? Are there any other amputations related to non-pressure ulcers that may not be assigned to the measure? Please explain your rationale.

Question 6: Risk Adjustment

The Non-Pressure Ulcers measure uses a robust risk adjustment model to account for patient-level factors outside the reasonable influence of the attributed clinician. The model includes standard risk adjustors from the CMS Hierarchical Condition Category (CMS-HCC) model: 86 HCC codes representing comorbidities, patient demographics (age), health status indicators (disability status, ESRD status, recent long-term care use), dual eligibility status, and types of clinician specialties from which the patient has received care.

Specific to the Non-Pressure Ulcers measure, additional risk adjustor variables include:

- Smoking
- Frailty
- Site of service
- Lymphedema
- Gunshot wounds
- Radiation
- Sleep apnea
- Ulcer instances
- Ulcer severity indicators

These measure-specific risk adjustors were selected because they are present at the start of care, have a clinical relationship with expected costs, show variation in prevalence, are not indicators of care provided, are resistant to gaming, and are not redundant with other variables.

Refer to the Draft Measure Codes List to see more information on the standard and measure-specific risk adjustors for the measure ("RA" and "RA_Details" tabs).

6. Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment? Please explain your rationale.

Question 7: Exclusions

Exclusions remove patient populations where there is extreme cost variability not susceptible to performance improvement. The Non-Pressure Ulcers measure excludes patients with a history of the following conditions, which are associated with ulcers that have different etiologies and treatment pathways than typical non-pressure ulcers:

- Pyoderma gangrenosum
- Calciphylaxis
- Sickle cell anemia
- Vasculitis
- Scleroderma
- Ulcers associated with fistulae
- Calcinosis cutis

7. Should there be any changes made to the current list of excluded episodes for the Non-Pressure Ulcers measure? Please explain your rationale.

Question 8: Quality Alignment

The intent is for the Non-Pressure Ulcers measure to be used in the MIPS Cost performance category. If added to MIPS in the future, it would be one part of the MIPS final score; the other performance categories are quality measures, improvement activities, and promoting interoperability.

8. Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Non-Pressure Ulcers measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale. *[Open response text box]*

Question 9: Actionability

A goal of episode-based cost measures is to provide clinicians with actionable information to improve patient care and cost efficiency.

9. Based on your understanding of the Non-Pressure Ulcers measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.

Question 10: Unintended Consequences

Episode-based cost measures are designed with multiple safeguards to minimize the risk of unintended consequences. Risk adjustment accounts for patient complexity so that clinicians are not penalized for treating higher-risk patients who may require more intensive or costly care. Service assignment ensures that only clinically related services within the clinician's reasonable influence are included in episode costs. Exclusions remove patient populations with extreme cost variability that is not susceptible to performance improvement. Sub-grouping ensures fair comparisons among clinicians with similar patient case mixes. Despite these safeguards, we want to ensure that the Non-Pressure Ulcers measure does not create incentives that could negatively impact patient care or access to services.

10. Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.

2.3 Parkinsonism Syndromes and Multiple Sclerosis

This section lists questions specific to the Parkinsonism Syndromes and MS measure.

Question 1: Trigger Codes / Patient Cohort

Parkinsonism Syndromes and MS episodes require both a trigger claim and a confirming claim billed by the same group practice within 1 to 180 days of each other to establish a patient-clinician relationship and open an episode:

- **A trigger claim** marks the start of an episode. It is a Part B Physician/Supplier claim for a clinically relevant outpatient service paired with an ICD-10 diagnosis code indicating a Parkinsonism Syndrome or MS.
- **A confirming claim** indicates the continuation of a patient-clinician relationship. It is a second Part B Physician/Supplier claim paired with a Parkinsonism Syndrome or MS diagnosis.

Note that following continued development discussions, Amyotrophic Lateral Sclerosis (ALS) was removed from the measure due to small sample sizes and variability in costs. The Clinician Expert Workgroup recommended changing the measure name to "Parkinsonism Syndromes and Multiple Sclerosis (MS)" to accurately describe the conditions included in the measure.

Refer to the Draft Measure Codes List to see the specific codes used to trigger and confirm a Parkinsonism Syndromes and MS episode ("Triggers_HCPCS" and "Triggers_DGN" tabs).

1. Do the trigger codes appropriately identify a patient cohort that reflects the measure intent to assess costs to Medicare for patients with Parkinsonism Syndromes or MS? If not, what changes would you recommend to ensure the measure captures the intended patient population? Please explain your rationale. *[Open response for each]*
    a. Do you have any feedback on the removal of ALS from the measure? Are there other conditions that should or should not be considered for inclusion in the Parkinsonism Syndromes and MS measure?
    b. Does the proposed measure name "Parkinsonism Syndromes and Multiple Sclerosis (MS)" appropriately describe the conditions included in the measure? If not, what alternative name would you suggest?

Note that patient heterogeneity within this overall patient cohort can be addressed through other parts of the measure construction (e.g., sub-groups, exclusions, risk adjustment).

Question 2: Attribution

Parkinsonism Syndromes and MS episodes are attributed at both the group (TIN) and individual clinician (TIN-NPI) levels:

- **Group level attribution:** The episode is attributed to the clinician group that billed the trigger and confirming claims. The group must also have at least one clinician who prescribed at least 2 condition-related medications to 2 different patients during the measurement period plus a one-year lookback period.
- **Clinician level attribution:** Within the attributed group, the episode is attributed to individual clinicians who billed at least 30% of trigger or confirming codes on Part B Physician/Supplier claim lines during the episode. Clinicians must also meet two additional requirements: (1) have billed at least one trigger or confirming code within 1 year prior to or on the episode start date, and (2) have prescribed at least 2 condition-related medications to 2 different patients during the measurement period plus a one-year lookback period.

The **trigger window**—the period during which the trigger and confirming claims must occur to establish a patient-clinician relationship—is 1 to 180 days.

The **medication prescribing requirement** ensures that attributed clinicians are actively involved in providing ongoing chronic care management for Parkinsonism Syndromes and MS patients. As a result, the measure is attributed to clinicians such as neurologists and nurse practitioners. Non-prescribing clinicians such as physical and occupational therapists and speech language pathologists are not attributed to this measure.

For a more detailed description of how we attribute episodes, please reference Section 4 of the Draft Measure Information Form (MIF).

2. Does the Parkinsonism Syndromes and MS measure appropriately attribute episodes to clinicians or groups who can reasonably influence costs related to Parkinsonism Syndromes and MS care? Do you have feedback on the medication prescribing requirement and exclusion of non-prescribing clinicians from attribution? Please explain your rationale.

Question 3: Episode Length

The episode window begins after the trigger window and represents the period during which cost outcomes are reasonably influenced by the attributed clinician. The minimum episode window is 365 days. If another trigger or confirming code is billed by the same group within the current episode window (i.e., a reaffirming claim), the episode extends by one year to indicate an ongoing care relationship.

Costs include those billed by the attributed clinician as well as downstream costs billed by non-attributed clinicians, representing outcomes of the attributed provider's care (e.g., a related hospitalization).

3. Does the minimum episode length of 365 days (with extensions for reaffirming claims) appropriately capture the period during which attributed clinicians can reasonably influence the costs of Parkinsonism Syndromes and MS care? Please explain your rationale.

Question 4: Sub-Grouping

The Parkinsonism Syndromes and MS measure stratifies episodes into two sub-groups based on the diagnosed condition. Since Parkinsonism Syndromes and MS are both progressive neurodegenerative disorders affecting movement but are otherwise unrelated diseases with different treatment pathways and cost profiles, risk adjustment is done separately for each sub-group so that episodes are only directly compared against other episodes in the same sub-group. The sub-groups are:

- Parkinson's and Related Conditions
- Multiple Sclerosis (MS)

Refer to the Draft Measure Codes List to see the specific diagnoses used to define the sub-groups ("Triggers_DGN" tab).

4. Is it reasonable to compare Parkinson's and Related Conditions episodes separately from MS episodes (i.e., run through separate risk adjustment models) due to expected differences in cost? Are there additional claims-based indicators we should consider when stratifying Parkinsonism Syndromes and MS episodes? Please explain your rationale.

Question 5: Service Assignment

The Parkinsonism Syndromes and MS measure assigns clinically related services that encompass variations in treatment options, intensity or duration of treatment, routine care and monitoring, acute exacerbations, complications, side effects from treatment, and supportive care. Services are identified using CPT/HCPCS codes on Part B claims, MS-DRGs on Part A inpatient claims, and NDC codes for Part D drugs. The measure currently includes the following service categories:

- Routine provider visits, lab/imaging services
- Physical/occupational/speech therapy services, durable medical equipment
- Pulmonary services, sleep-related studies, nutrition services, gastrointestinal services, behavioral health services
- Part D medications, infusion therapy
- Urinary tract infection, pressure injuries, pneumonia, medication toxicity syndromes, subdural hematomas, contractures, hip fractures and joint replacements, other fall-related care
- Related inpatient hospitalizations, related post-acute care, other home health services, other emergency department visits

Note that following continued development discussions, the draft measure no longer includes services related to Deep Brain Stimulation (DBS) or Intrathecal Pumps. These services were removed due to the low frequency of use and high associated costs, which created significant variability that was difficult to account for through risk adjustment.

Refer to the Draft Measure Codes List to see the specific services included in service assignment ("Service_Assignment_AB" and "Service_Assignment_D" tabs).

5. Are these service categories appropriate to include in the measure? Are there services that should be added or removed to better capture an attributed clinician's performance for Parkinsonism Syndromes and MS care? Do you have any feedback on the removal of DBS and Intrathecal Pump services from the measure? Please explain your rationale.

Question 6: Risk Adjustment

The Parkinsonism Syndromes and MS measure uses a robust risk adjustment model to account for patient-level factors outside the reasonable influence of the attributed clinician. The model includes standard risk adjustors from the CMS Hierarchical Condition Category (CMS-HCC) model: 86 HCC codes representing comorbidities, patient demographics (age), health status indicators (disability status, ESRD status, recent long-term care use), dual eligibility status, and types of clinician specialties from which the patient has received care.

Specific to the Parkinsonism Syndromes and MS measure, additional risk adjustor variables include:

- Dependence on respirator
- Frailty
- Other degenerative diseases of basal ganglia
- Past bowel or bladder incontinence
- Past cognitive status impairment
- Decline or deficit
- Past difficulty swallowing
- Past dysarthria and anarthria
- Past dysphonia
- Past sleep apnea
- History of falling
- Past contracture diagnoses
- Wheelchair dependence

Note that following continued development discussions, the measure no longer risk adjusts for ALS, DBS, or Intrathecal Pump because these conditions and services have been removed from the measure.

These measure-specific risk adjustors were selected because they are present at the start of care, have a clinical relationship with expected costs, show variation in prevalence, are not indicators of care provided, are resistant to gaming, and are not redundant with other variables.

Refer to the Draft Measure Codes List to see more information on the standard and measure-specific risk adjustors for the measure ("RA" and "RA_Details" tabs).

6. Are there any changes that should be made to the current list of standard and measure-specific risk adjustors (such as adding or removing variables)? Are there additional patient-level indicators we should account for in risk adjustment? Do you have any

feedback on the removal of the measure-specific risk adjustors for DBS and Intrathecal Pumps? Please explain your rationale.

Question 7: Exclusions

Exclusions remove patient populations where there is extreme cost variability not susceptible to performance improvement. The Parkinsonism Syndromes and MS measure excludes patients with the following conditions, which are associated with treatment pathways or cost profiles that differ significantly from typical Parkinsonism or MS episodes:

- Microvascular decompression
- Spinal cord injury
- Stereotactic radiosurgery

7. Should there be any changes made to the current list of excluded episodes for the Parkinsonism Syndromes and MS measure? Please explain your rationale.

Question 8: Quality Alignment

The intent is for the Parkinsonism Syndromes and MS measure to be used in the MIPS Cost performance category. If added to MIPS in the future, it would be one part of the MIPS final score; the other performance categories are quality measures, improvement activities, and promoting interoperability. Some quality measures related to this measure include MIPS Clinical Quality Measures #Q290: Assessment of Mood Disorders and Psychosis for Patients with Parkinson's Disease, #Q291: Assessment of Cognitive Impairment or Dysfunction for Patients with Parkinson's Disease, and #Q293: Rehabilitative Therapy Referral for Patients with Parkinson's Disease.

8. Which quality measures or quality indicators (e.g., effective care coordination, timely follow-up) are the most relevant to the Parkinsonism Syndromes and MS measure to assess the value of care? Are there indicators of quality that are not currently captured in a MIPS quality measure? Please explain your rationale.

Question 9: Actionability

A goal of episode-based cost measures is to provide clinicians with actionable information to improve patient care and cost efficiency.

9. Based on your understanding of the Parkinsonism Syndromes and MS measure, can you identify specific clinical actions or practice changes that could improve performance on this measure while maintaining or improving quality of care? Please explain.

Question 10: Unintended Consequences

Episode-based cost measures are designed with multiple safeguards to minimize the risk of unintended consequences. Risk adjustment accounts for patient complexity so that clinicians are not penalized for treating higher-risk patients who may require more intensive or costly care. Service assignment ensures that only clinically related services within the clinician's reasonable influence are included in episode costs. Exclusions remove patient populations with extreme cost variability that is not susceptible to performance improvement. Sub-grouping ensures fair comparisons among clinicians with similar patient case mixes. Despite these safeguards, we

want to ensure that the Parkinsonism Syndromes and MS measure does not create incentives that could negatively impact patient care or access to services.

10. Are there potential unintended consequences of this measure that should be considered? For example, could the measure inadvertently discourage appropriate care or create barriers to access for certain patient populations? Please explain.

3.0 Field Testing Questions

3.1 Field Test Reports

If you did not receive a field test report, you can review a mock field test report here to see what metrics are provided.

1. The field test reports contain a number of tables with information about cost performance. For example, one such table provides a breakdown of costs by Medicare settings coding systems. The services included in the measure are grouped into clinically meaningful categories using either a single code or a set of codes, based on existing categorizations and clinical input. One of the coding taxonomies that the table uses is the Restructured BETOS Classification System (RBCS) categories, where were further adapted/augmented for the purposes of field testing to group service codes into clinically meaningful categories. These costs are compared to the national average and providers with a similar patient case-mix. Please provide a response to each of the questions below:
    - Across these tables, which are the most useful service categories for helping you to understand the cost measure and provide feedback on its clinical validity?
    - Are there different types of service or cost breakdowns that would be useful (e.g., more or less granular)?
    - How important is it to have standardized metrics across measures, since clinicians may receive multiple field test reports?
    - Are there other comparisons beside national average and providers with similar patient case-mixes that would be useful for understanding the cost measure and how it assesses performance?

2. Please provide comments about the presentation, content, and clarity of the sections within the Cost Measure Field Test Report listed below. Include any suggestions on how we can improve its readability, usefulness, and actionability of the information presented in these sections, particularly in terms of having sufficient information to provide feedback on the draft measure specifications.
    - Overview and Measure Score
    - Breakdown of Cost Measure Performance
    - Episode Costs
    - Additional Information
    - CSV with episode-level results

3. What information was the most useful for helping you to understand the cost measure and provide feedback? Options are listed below.
    - Mock field test reports

- Draft measure specifications
- At-A-Glance documents
- Field testing FAQ
- Field Testing Presentation recording
- Field Test Report Walkthrough recordings
- Measure Testing Forms

4. What other feedback do you have about the field test reports?

3.2 Technical Specifications

5. The draft measure specifications include various components: measure construction methodology, quick reference specifications, measure flowchart, and codes list. Which part of the specification documentation do you find the most useful for understanding the measure? Options are listed below.
    - Measure construction methodology
    - Quick reference specifications
    - Measure flowcharts
    - Codes list
    - Other (specify)

6. Do you have any feedback about the draft measure specifications documentation?

3.3 Education and Outreach

7. How did you find out about field testing? Options are listed below:
    - Received CMS email notification
    - Received Acumen email notification
    - Attended field testing webinar
    - Was notified by specialty society / professional association
    - Was notified by clinical practice
    - Saw on the CMS MACRA website
    - Other (specify)

4.0 Upload a Comment Letter

Comments may be submitted by uploading documents through the survey link: https://acumen.qualtrics.com/jfe/form/SV_bydizySYqsIUifs. Only PDF, DOC, and DOCX files are supported.

5.0 Thank You for Your Comment

Thank you for completing the 2026 Cost Measures Field Testing Feedback Survey. We appreciate your feedback, and will take your comments into consideration for measure refinement and any future measure development activities.

Should you have further questions or want more information, please contact the Quality Payment Program Service Center via telephone at 1-866-288-8292 or via email at qpp@cms.hhs.gov. The Help Desk is available Monday – Friday; 8:00 a.m. – 8:00 p.m. Eastern Standard Time.