Quality Payment
PROGRAM

2026 Cost Measures Field Testing Frequently Asked Questions (FAQ)

Winter 2026 Field Testing

Table of Contents

1.0 Overview 4

1.1 What is field testing? 4
1.2 Which cost measures are being field tested? 5
1.3 Do the cost measures being field tested affect my 2026 MIPS score? 5
1.4 How were these cost measures developed? 5
1.5 Why were these measures selected for field testing? 6
1.6 What is new in this round of field testing? 6

2.0 Participating in Field Testing 6

2.1 When does field testing take place? 6
2.2 Do I need to register to participate in field testing? 6
2.3 Why should I participate? 6
2.4 What feedback are you looking for? 7
2.5 How can I give feedback? 7
2.6 How will you use my feedback? 7
2.7 Can I still provide feedback on the measures even if I didn't receive a report? 7
2.8 Will there be webinars or office hours during field testing? 8
2.9 How can I sign up for updates about cost measures? 8

3.0 Field Test Reports 8

3.1 Who can receive a Field Test Report? 8
3.2 What is the format of the Field Test Reports? 8
3.3 How can I access my Field Test Report(s)? 9
3.4 What data were used to calculate the measures for the Field Test Reports? 9
3.5 How many Field Test Reports are there? 10
3.6 How many clinicians/clinician groups received one or multiple Field Test Reports? 10
3.7 How can I use the information in the Field Test Report? 10

4.0 Background on Episode-Based Cost Measures 11

4.1 What are episode-based cost measures? 11
4.2 How are episodes attributed to a clinician? 11
4.3 What services and costs are included in an episode? 11
4.4 Which measures include Part D costs? 12
4.5 Do the measures use standardized costs? 12
4.6 What is risk adjustment? 12
4.7 How does testing address non-clinical factors such as dual status and provider location? 13
4.8 How are episode-based cost measures calculated? 13
4.9 Where can I find the draft measure specifications and testing results? 14

5.0 Cost Measures in MIPS 14

5.1 When will these cost measures be used in MIPS? 14
5.2 How would these cost measures fit within in MIPS? 14
5.3 Can these cost measures be used in MVPs now? 15

6.0 Who Can I Contact for More Information? 15

Acronyms and Abbreviations

Table 1.1 Acronyms and Abbreviations

Acronym and/or Abbreviation	Description
CKD	Chronic Kidney Disease
CMS	Centers for Medicare & Medicaid Services
CMS-HCC ESRD	CMS Hierarchical Condition Category End-Stage Renal Disease
CMS-HCC V24	CMS Hierarchical Condition Category Version 24
COPD	Chronic Obstructive Pulmonary Disease
CPT/HCPCS	Current Procedural Terminology/Healthcare Common Procedure Coding System
CSV	Comma-Separated Values
E/M	Evaluation and Management
ESRD	End-Stage Renal Disease
GPCI	Geographic Prices Cost Index
HARP	Health Care Quality Information Systems (HCQIS) Access Roles and Profile
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MIPS	Merit-based Incentive Payment System
MVPs	MIPS Value Pathways
NPI	National Provider Identifier
PFE	Person and Family Engagement
PFP	Person and Family Partners
QPP	Quality Payment Program
TEP	Technical Expert Panel
TIN	Taxpayer Identification Number

1.0 Overview

1.1 What is field testing?

Field testing, also known as beta testing, is part of the measure development and testing process outlined by the CMS Measures Management System (MMS).[1] This testing occurs after development of initial technical specifications and is an opportunity to assess scientific acceptability (i.e., the extent to which the measure produces valid and reliable results about the intended area of measurement) and usability (i.e., whether people or organizations can effectively use a measure). Field testing also provides additional evidence to support importance and feasibility evaluations. More information about measure evaluation criteria is available on the MMS Hub.[2]

Field testing is also an opportunity for clinicians and other interested members of the public to learn about episode-based cost measures and to provide input on the draft specifications. During field testing, we'll:

- Calculate the measures as currently specified for all clinicians (group practices and individuals) who have sufficient episodes to meet the testing volume threshold
- Summarize results in Field Test Reports, which are available to group practices and individuals on the Quality Payment Program (QPP) website[3]
- Post draft measure specifications (i.e., measure methodology and codes lists) and supplemental documentation, such as testing results, on the QPP Cost Measure Information Page[4]
- Collect feedback on the draft specifications for each measure through an online survey:
- 2026 Cost Measures Field Testing Feedback Survey[5] for most feedback, including input on the measures, their draft specifications, the Field Test Reports, and other field testing materials
- Person and Family Engagement (PFE) Field Testing Survey[6] for people with lived experience, as a patient or a caregiver, with the conditions represented in the measures undergoing field testing

Field testing is being conducted as part of the PCMP Cost Measure Development Project. The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC (referred to as "Acumen") to develop new episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS).

[1] MMS, "Measure Testing Process," https://mmshub.cms.gov/measure-lifecycle/measure-testing/process/overview
[2] MMS, "Measure Evaluation Criteria," https://mmshub.cms.gov/measure-lifecycle/measure-testing/evaluation-criteria
[3] CMS, "Quality Payment Program Account," Quality Payment Program, https://qpp.cms.gov/login.
[4] These documents will be available on the QPP Cost Measure Information Page once field testing begins. https://www.cms.gov/medicare/quality/value-based-programs/cost-measures
[5] The general field testing online survey will open beginning January 29, 2026 at this link: https://acumen.qualtrics.com/jfe/form/SV_bydizySYqslUifs
[6] The person and family field testing online survey will open beginning January 29, 2026 at this link: https://acumen.qualtrics.com/jfe/form/SV_cGg6Zd5WPWWdn6e

1.2 Which cost measures are being field tested?

The episode-based cost measures that are being field tested include:

- Breast Cancer Screening (Wave 7)
- Non-Pressure Ulcers (Wave 6 Continued Development)
- Parkinsonism Syndromes and Multiple Sclerosis (MS) (Wave 6 Continued Development)

1.3 Do the cost measures being field tested affect my 2026 MIPS score?

No. These measures aren't part of MIPS, so they don't count toward your cost performance category or MIPS final score. As such, they don't affect any payment adjustments. The purpose of field testing is to gather feedback on the draft specifications during the measure development process so that we can make any updates before CMS considers whether to use these measures in MIPS.

1.4 How were these cost measures developed?

Acumen's measure development approach involves gathering input from clinical experts and other interested parties through multiple channels, empirically testing the measures, and conducting environmental scans. We develop measures in cycles ("Waves") where we undertake these activities iteratively to build out and test measures. Table 1 describes the role of the different input channels in this process.

Table 1. Input Gathered to Date

Input Channel	Description of Role
Technical Expert Panel (TEP)	Serves as a high-level advisory role across the project. Provided guidance on the framework for assessing the costs of care and measure prioritization at 15 meetings from 2016-2025, including August 2016, December 2016, March 2017, August 2017, May 2018, November 2018, December 2018, February 2020, July 2021, two in August 2022, September 2023, March 2024, December 2024, and August 2025.
Public Comment	Provided input on candidate measure concepts, how to address clinical and coding challenges, and what types of expertise would be needed to compose workgroups for Wave 6 and Wave 7 measures.
Clinician Expert Workgroups ("Workgroups")	Provided input on each aspect of measure specifications for Wave 6 measures through meetings in June-October 2023, March 2024, and July-October 2025 (continued development). Wave 7 (Breast Cancer Screening) workgroups met in July and October 2025. Composed of clinicians with experience and expertise for the specific condition.
Patient and Family Partners (PFPs)	Provided input on aspects of measures via focus groups and interviews, and shared the input with Workgroups. PFPs are caregivers and individuals with lived experience with particular health conditions.

For more information on measure development, refer to the 2026 Episode-Based Cost Measures Field Testing Wave 6 and Wave 7 Measure Development Process document on the QPP Cost Measure Information Page.

1.5 Why were these measures selected for field testing?

The three cost measures listed in Question 1.2 are being field tested as part of the measure development process, prior to being considered for potential use in MIPS. These measures were chosen for development because they represent new clinical areas, prioritize specialty gap areas, and build more in-depth measurement for high-cost areas. They also meet the general criteria for measure prioritization as they are clinically coherent and impactful, offer opportunities for improvement, and can align with quality. These measures have all gone through iterative development and testing and are now at the field testing stage of the development process, from which we'll gather feedback on the measures prior to measure refinement and finalization.

1.6 What is new in this round of field testing?

This round of field testing includes several updates based on feedback from prior field testing:

- **Continued Development of Wave 6 Measures:** The Non-Pressure Ulcers and Parkinsonism Syndromes and MS measures have undergone continued development following the 2024 Measures Under Consideration (MUC) List and Pre-Rulemaking Measure Review (PRMR) process. The Clinician Expert Workgroups reconvened in July and September/October 2025 to consider updates to the measure specifications based on stakeholder and clinical expert feedback.
- **New Wave 7 Measure:** The Breast Cancer Screening measure is a new procedural measure being field tested for the first time.
- **Enhanced Report Context:** Field Test Reports include more context and guidance on the report metrics to help clinicians understand their performance.
- **Updated Educational Materials:** Updated educational materials and outreach efforts are available to help clinicians and other interested parties understand the measure specifications and how to navigate the reports.

2.0 Participating in Field Testing

2.1 When does field testing take place?

Field testing will last for 4 weeks, from January 29 to February 27, 2026 (11:59 p.m. ET).

2.2 Do I need to register to participate in field testing?

No, you don't need to register to participate in field testing. You may submit your feedback on the measures' draft specifications using the general field testing online survey.[7] If you're eligible to receive a Field Test Report, you'll need a QPP account to access the report(s). The 2026 Cost Measure Field Test Report User Access Guide on the QPP Cost Measure Information Page contains more information about the QPP website and how to register for an account.

2.3 Why should I participate?

Field testing is a chance for all interested members of the public to provide feedback on the measures during the development process. Your participation allows us to consider your

[7] There's a separate online survey meant for Person and Family Engagement (PFE). See Question 2.5 for more details.

feedback as part of refining and finalizing the measures in 2026 before CMS considers these for use in MIPS.

2.4 What feedback are you looking for?

We're looking for feedback on:

- The draft measure specifications of the three episode-based cost measures.
- Whether the information presented in the Field Test Report helps you identify actionable improvements to patient care and cost efficiency.
- Whether the field testing materials present the information in a way that explains the measures.

The survey contains specific questions about each measure. The questions are also listed in the Questions for Field Testing Measure Specifications document on the QPP Cost Measure Information Page.

2.5 How can I give feedback?

You can share your feedback through the online 2026 Cost Measures Field Testing Feedback survey.[8] You can answer questions about the measures or upload a PDF or Word document. You may submit comments anonymously if you prefer.

There's a separate online survey meant for Person and Family Engagement (PFE), which is the 2026 PFE Cost Measures Field Testing Feedback Survey.[9] Patients, caregivers, and family members with applicable lived experiences with the conditions of the cost measures are encouraged to provide their input in this survey to help inform refinement discussions.

2.6 How will you use my feedback?

After field testing, we'll summarize your feedback and share it with the measure-specific Clinician Expert Workgroups. They'll be able to consider this input as they work to finalize the measure specifications to wrap up the development process. After this, CMS may consider the final measure for use in MIPS.

We'll also produce a summary report of all the field testing feedback that will be publicly posted. Your feedback will also be used to inform how the measures can be improved to provide clinicians with actionable information to ensure high quality and high-value care.

2.7 Can I still provide feedback on the measures even if I didn't receive a report?

Yes. We encourage all interested parties to review publicly available field testing materials and provide feedback by completing the online 2026 Cost Measures Field Testing Feedback Survey[10] when they become available on the QPP Cost Measure Information page:

[8] The online 2026 Field Testing Feedback Survey will be open beginning January 29, 2026, at this link: https://acumen.qualtrics.com/jfe/form/SV_bydizySYqslUifs

[9] The PFE Cost Measures Field Testing Feedback Survey will be open beginning January 29, 2026, at this link: https://acumen.qualtrics.com/jfe/form/SV_cGg6Zd5WPWWdn6e

[10] The field testing online survey will be open beginning January 29, 2026, at this link: https://acumen.qualtrics.com/jfe/form/SV_bydizySYqslUifs

- Field Test Report User Access Guide
- Measure Development Process Document
- Questions for Field Testing Measure Specifications
- Methodology Documents and Codes Lists for each measure
- Mock Field Test Reports for each measure
- Measure Testing Form for each measure
- At-A-Glance Measure Summary for each measure

2.8 Will there be webinars or office hours during field testing?

Yes. Acumen will share pre-recorded webinars that outline the draft measure specifications, explain what is contained in field test reports, and provide details on how to participate. Specialty society office hours are also held for specialty societies who represent specialties that are likely to be attributed the measures undergoing testing. These sessions provide information about Field Test Reports and how they can be accessed, how to submit comments, and how to access additional information about the measures. They provide opportunities for question-and-answer to improve the public's understanding.

Information about recorded webinars will be posted on the QPP Cost Measure Information Page.

2.9 How can I sign up for updates about cost measures?

Members of the public can sign up for email updates via listservs to receive regular updates on measure development and reevaluation. If you would like to receive updates from Acumen on PCMP activities, such as measure development, please fill out this form.[11]

3.0 Field Test Reports

3.1 Who can receive a Field Test Report?

Clinicians and group practices who meet the minimum episode volume threshold for the measures will receive a Field Test Report. If you meet this criterion for receiving a Field Test Report for more than one cost measure, you'll receive more than one measure-specific report.

Note: The measures only include patients with Traditional Fee-For-Service (FFS) Medicare. Patients enrolled in Medicare Advantage (Part C) are not included in the measure calculations.

3.2 What is the format of the Field Test Reports?

The Field Test Reports will be compiled and available for download in one zip file containing:

- A measure-specific report in PDF file format
- Episode-level information in Comma-Separated Values (CSV) file format
- A data dictionary for the episode-level file in Excel file format

[11] "Acumen, Physician-level Cost Measures and Patient Relationship Codes (PCMP) Mailing list" https://survey.zohopublic.com/zs/Fbzc07

3.3 How can I access my Field Test Report(s)?

You or your group's authorized representative can access the Field Test Report(s) using a Quality Payment Program website account and the same account information that you use to submit data and view performance feedback. If you don't have an account, you'll need to register for a Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) account in order to sign in.[12] Once you have access, you can connect with your organization by navigating to the "Sign In" tab of the Quality Payment Program website. If you're part of a clinician group, you'll select the "practice" organization type, and if you're an individual clinician, you'll select the "individual clinician" organization type.

The Quality Payment Program Access User Guide (ZIP) provides more information on how to sign up for a Quality Payment Program account and how to connect with the appropriate organization.[13]

Groups are identified by their Medicare billing TIN. A group consists of 2 or more eligible clinicians, as identified by their NPIs that bill under the same TIN. A group will receive a Field Test Report if the TIN is attributed the minimum number of cases for a measure among all NPIs billing under the TIN. For a Quality Payment Program account, a group can have either of the following roles:

- Security Official
- Staff User

Users who have a Security Official role will be able to see all TIN-NPI reports within their TIN, as well as the TIN's overall report, so it's a role that's more appropriate for someone who is in an administrative position at the group. Each organization must have a Security Official role before any other group members can request a Staff User role. The group-level users (i.e., Security Official and Staff Users) have access to the group practice's reports and the individual-level reports for the solo practitioners within the group practice.

An individual eligible clinician (or a solo practitioner) is identified by a single NPI that bills under the TIN. They'll receive a Field Test Report if the NPI is attributed the minimum number of cases for a measure. Clinicians looking to view only their TIN-NPI report should connect to the individual clinician organization type, regardless of whether they're a part of a group practice or they practice on their own. The Field Test Report Access User Guide on the QPP Cost Measure Information Page provides more information on accessing a Field Test Report.

Note: Field test reports are separate from the Quality Payment Program Performance Feedback Reports; however, this is the same website where those reports are made available. Additionally, individuals using assistive technology may not be able to fully access information in this file. To request a fully accessible report, contact qpp@cms.hhs.gov.

3.4 What data were used to calculate the measures for the Field Test Reports?

The measurement period for the Field Test Reports is January 1 to December 31, 2024. Episodes are constructed and measures are calculated using Medicare Parts A, B, and D

[12] CMS, "Quality Payment Program Account," Quality Payment Program, https://qpp.cms.gov/login?page=register

[13] CMS, "Quality Payment Program Access User Guide," Quality Payment Program, https://qpp.cms.gov/resource/2019%20QPP%20Access%20User%20Guide.

claims data from the Common Working File, as well as data from the Enrollment Database and Long Term Care Minimum Data Set.

3.5 How many Field Test Reports are there?

Table 2 includes the number of Field Test Reports available for each measure.

Table 2. Number of Field Test Reports for Each Measure

Episode-Based Cost Measure	Number of Group Reports	Number of Clinician Reports
Breast Cancer Screening	2,369	17,464
Non-Pressure Ulcers	3,730	3,809
Parkinsonism Syndromes and MS	3,115	2,884

3.6 How many clinicians/clinician groups received one or multiple Field Test Reports?

Table 3 below presents the number of groups and clinicians by the number of cost measures for which they received a Field Test Report.

Table 3. Number of Groups/Clinicians by Number of Episode-based Cost Measures Attributed

Number of Measures	Number of Groups	Number of Clinicians
1	6,218	24,143
2	898	7
3	400	0

3.7 How can I use the information in the Field Test Report?

You may use the data in your Field Test Report(s) to understand the cost measures and provide feedback on them.

The Field Test Reports present information intended to:

- Illustrate the types of services that comprise a large or small share of episode costs.
- Show the variation in clinician cost measure performance across different types of services or Medicare settings (claim types).
- Show which other Medicare clinicians account for patient costs during the episode.

4.0 Background on Episode-Based Cost Measures

4.1 What are episode-based cost measures?

Episode-based cost measures represent the cost to Medicare for the items and services furnished to a patient during an episode of care ("episode"). The term "cost" generally means the Medicare allowed amount, which includes both Medicare and trust fund payments and any applicable deductible and coinsurance amounts on traditional, fee-for-service claims.

An episode includes the costs from services that are clinically related to the care being assessed during a defined period, called the episode window. They include services that identify the clinician who is managing or treating a patient's condition, routine care services, and consequences of care. Episodes don't include services that are clinically unrelated.

The measure sums up the costs during the episode window, and risk-adjusts them. Risk adjustment neutralizes the effects of risk factors deemed to be outside a clinician's influence (e.g., age, pre-existing conditions).

4.2 How are episodes attributed to a clinician?

Attribution is based on identifying the clinician responsible for the care being assessed. We use service and diagnosis information from claims to attribute episodes to clinicians. The codes and methodology used in attribution vary by measure type:

For procedural measures (e.g., Breast Cancer Screening), the episode is attributed to the clinician who performs the triggering procedure. The clinician performing the procedure is identified by the rendering clinician on the claim for the triggering service.

For chronic condition measures (e.g., Non-Pressure Ulcers, Parkinsonism Syndromes and MS), attribution is based on identifying the start of a clinician-patient relationship for the care being assessed. A trigger event (a pair of services for the treatment or management of the condition billed by the same clinician group) identifies the clinician group responsible for the care. The episode is then attributed to individual clinicians within the attributed group who billed a sufficient share (at least 30%) of the trigger/confirming claims.

For detailed measure specifications, please refer to the Draft Cost Measure Methodology documents and Draft Measure Costs Lists files for each measure on the QPP Cost Measure Information Page.

4.3 What services and costs are included in an episode?

Services are assigned to an episode only when clinically related to the management and treatment of a patient's condition during the episode. Assigned services might include treatment and diagnostic services, and ancillary items and services directly related to treatment (e.g., anesthesia for a surgical procedure). Services furnished as a consequence of care, such as complications, readmissions, unplanned care, and emergency department visits may also be included. Related outpatient services (e.g., follow-up consultations, patient home visits, and therapeutic procedures) are also included in the measures.

The measures don't include clinically unrelated services. For example, a measure focused on the management of non-pressure ulcers wouldn't include the costs of a cataract removal procedure as it's clinically unrelated to the care for non-pressure ulcers.

For detailed measure specifications, please refer to the Draft Cost Measure Methodology documents and Draft Measure Costs Lists files for each measure on the QPP Cost Measure Information Page.

4.4 Which measures include Part D costs?

The Non-Pressure Ulcers and Parkinsonism Syndromes and MS measures being field tested this year include clinically-related Part D costs. The workgroup for each measure considered the inclusion of Part D costs and recognized its importance based on various criteria, including: (i) the type of care being assessed, (ii) whether Part D costs make up a substantial portion of care, and (iii) if the inclusion of Part D costs is necessary to assess clinician performance. A list of the included Part D drugs are available in the Draft Measure Costs Lists files for each measure on the QPP Cost Measure Information Page.

The Breast Cancer Screening measure does not include Part D costs, as prescription drug costs are generally not a significant component of care for breast cancer screening episodes.

4.5 Do the measures use standardized costs?

Yes. Payment standardization for Parts A and B adjusts the allowed amount for a Medicare service to facilitate cost comparisons and limit observed differences in costs to those that may result from healthcare delivery choices. Payment standardized costs remove the effect of differences in Medicare payment among healthcare providers that are the result of differences in regional healthcare provider expenses measured by hospital wage indexes and geographic price cost indexes (GPCIs) or other payment adjustments, such as those for teaching hospitals.[14]

Part D standardization is designed to remove non-clinical sources of cost variation. This allows for resource use comparisons across providers who prescribe the same drug, even if the drug products are covered under different Part D plans, produced by different manufacturers, or dispensed by separate pharmacies.[15] The Part D standardization methodology also incorporates rebates into standardized amounts.[16]

4.6 What is risk adjustment?

Risk adjustment is a statistical technique to neutralize the effects of risk factors deemed to be outside of a clinician's influence. When we adjust for risk factors, we aim to isolate the variation in clinicians' costs to Medicare to those costs that clinicians can reasonably control. Accounting

[14] CMS, "CMS Part A and Part B Price (Payment) Standardization - Detailed Methods," https://resdac.org/sites/datadocumentation.resdac.org/files/CMS%20Part%20A%20and%20Part%20B%20Price%20%28Payment%29%20Standardization%20-%20Detailed%20Methods%20%28updated%20May%202022%29.pdf

[15] CMS, "CMS Part D Price (Payment) Standardization," https://resdac.org/sites/datadocumentation.resdac.org/files/CMS%20Part%20D%20Price%20%28Payment%29%20Standardization%20Methodology%20%28October%202021%29.pdf

[16] CMS, "General information about cost measures," QPP Cost Measure Information Page, https://www.cms.gov/medicare/quality/value-based-programs/cost-measures

for these factors is one way to make sure the measures are fairly comparing clinicians with different patient case mixes on cost performance.

Each measure has its own risk adjustment model to control for variables that affect expected costs for that condition. The CMS Hierarchical Condition Category Version 24 (CMS-HCC V24) 2021 Risk Adjustment Model is the base model for the Breast Cancer Screening, Non-Pressure Ulcers, and Parkinsonism Syndromes and MS measures. The Workgroups provide input based on clinical expertise and review of empirical data to customize each model with additional variables specific to the measure.

4.7 How does testing address non-clinical factors such as dual status and provider location?

Beyond clinical characteristics of patients, the cost of care may be influenced by non-clinical factors such as location or coverage eligibility. Beneficiaries located in rural versus urban areas may face different barriers to accessing care. Additionally, beneficiaries eligible for dual Medicare and Medicaid enrollment status have been historically shown as a more vulnerable population, more likely to experience poor outcomes.

At the program level, MIPS adjusts for these factors using the MIPS Complex Patient Bonus to ensure clinicians or groups treating more complex patients are not disadvantaged. At the measure-level, testing helps to navigate the tension between ensuring fairness for clinicians treating higher shares of vulnerable patients and the possibility of masking poor performance and perpetuating disparity if clinicians are held to different standards.

As part of field testing, we conduct analyses examining the associations between non-clinical factors, including dual Medicare and Medicaid enrollment status and provider location (urban versus rural), and measure performance. These analyses help determine whether it is appropriate to adjust for these factors in the risk adjustment model. The analyses consider:

- Whether dual status or provider location is associated with measure performance
- Whether the association is at the patient-level or clinician-level
- Whether patient need, rather than poor quality, is driving differences
- How dual status adjustment or provider location would affect measure performance rankings

Please see the Measure Testing Forms on the QPP Cost Measure Information Page for these results.

4.8 How are episode-based cost measures calculated?

An episode-based cost measure score is the clinician's or clinician group's average risk-adjusted cost for the measure. To calculate the score, we calculate the average ratio of observed cost to expected cost (as predicted through the risk adjustment model) across all attributed episodes, and multiply it by the national average observed episode cost.

For the chronic condition measures (Non-Pressure Ulcers and Parkinsonism Syndromes and MS), which can have variable episode lengths, costs are scaled to a standard period (90 days for Non-Pressure Ulcers, 365 days for Parkinsonism Syndromes and MS) to enable fair comparison across episodes of different lengths.

A lower measure score indicates that the observed episode costs are lower than or similar to expected costs for the care provided for the particular patients and episodes included in the calculation, whereas a higher measure score indicates that the observed episode costs are

higher than expected for the care provided for the particular patients and episodes included in the calculation. Therefore, a lower score is better (i.e., this is an inverse measure).

4.9 Where can I find the draft measure specifications and testing results?

These are posted on the QPP Cost Measure Information Page.

5.0 Cost Measures in MIPS

5.1 When will these cost measures be used in MIPS?

The earliest that these measures could be used or implemented in MIPS would be in the 2028 MIPS performance period / 2030 MIPS payment year. However, the earliest that these cost measures could contribute to a clinician's MIPS score is in the 2030 MIPS performance period/ 2032 MIPS payment year.

For the first two years that a measure is in use in MIPS, CMS will now provide informational-only feedback on clinicians' measure performance and the measure will not contribute to their MIPS score. More information about this informational-only feedback period is available in the CY 2026 PFS final rule.

5.2 How would these cost measures fit within in MIPS?

In the 2026 MIPS performance period, there are 35 cost measures in the MIPS cost performance category. How would these cost measures fit within MIPS?

If these measures are implemented in MIPS, they would be used in the cost performance category. By statute, the Cost Performance category is weighted at 30% of the MIPS final score starting from the 2022 performance period onward. In the 2026 MIPS performance period, the category includes 35 episode-based cost measures. There are two population-based measures that focus on inpatient and primary care. The remaining 33 measures are episode-based cost measures that span a range of procedures and chronic and acute inpatient medical conditions. Detailed measure specifications for these cost measures are available on the QPP Cost Measure Information page and the QPP Resource Library Page.

The cost performance category is one of 4 categories, so these measures would be considered alongside other metrics if they are implemented in MIPS. Clinicians participating in MIPS receive a payment adjustment based on a MIPS final score that assesses practice-specific data in 4 performance categories: (i) quality, (ii) cost, (iii) improvement activities, and (iv) Promoting Interoperability.

The cost measures being field tested could also potentially be used in future, applicable MIPS Value Pathways (MVPs) if they're finalized for use in MIPS. MVPs is a participation framework that aims to align and connect measures and activities across the quality, cost, and improvement activities performance categories. Cost is an essential component in assessing value and it's important to consider how to align cost with quality.

5.3 Can these cost measures be used in MVPs now?

MVPs must include at least one cost measure relevant and applicable to the MVP topic. MVPs must include cost measures currently in use in MIPS in order to be considered feasible. Therefore, the cost measures currently being field tested could be considered for inclusion in viable MVPs if they're used or implemented in MIPS and cover an applicable specialty/clinical topic for MVP development. The MVP Candidate Development & Submission webpage contains more information on MVP development resources/criteria.[17]

6.0 Who Can I Contact for More Information?

If you have further questions, please contact the QPP Service Center:

- Email: qpp@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 TRS Communications Assistant.

[17] QPP MVPs Page, https://qpp.cms.gov/mips/mips-value-pathways/submit-candidate. Direct downloadable link to resources page within the above link can be found here: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1803/MIPS%20Value%20Pathways%20(MVPs)%20Development%20Resources.zip