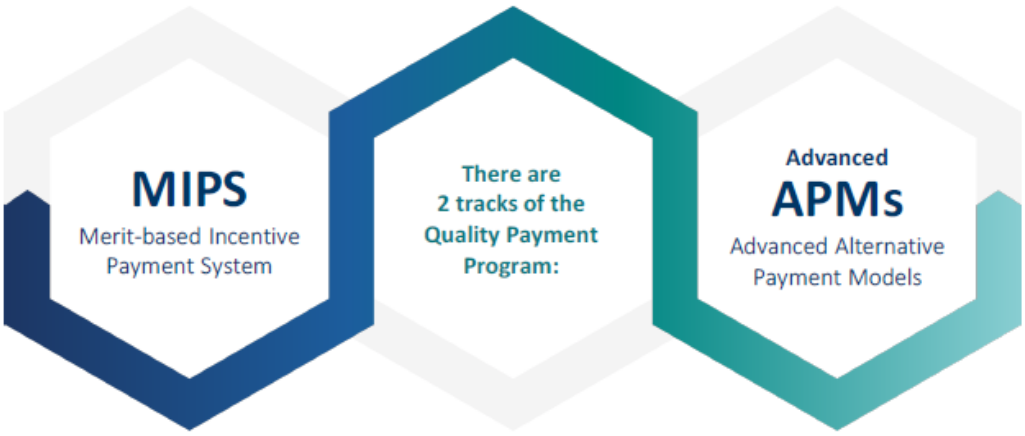
Quality Payment
PROGRAM

2026 MIPS Annual Call for Cost Measures Fact Sheet

Overview

1. What is the Quality Payment Program (QPP)?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (H.R. 2, Pub.L. 114–10) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. In response to MACRA, the Centers for Medicare & Medicaid Services (CMS) created a federally mandated Medicare program, the Quality Payment Program (QPP) that seeks to improve patient care and outcomes while managing the costs of services patients receive. Clinicians providing high value/high quality patient care are rewarded through Medicare payment increases, while clinicians not meeting performance standards have a reduction in Medicare payments. Clinicians may participate in the QPP through the following ways:



Under the Merit-based Incentive Payment System (MIPS), performance is assessed across 4 performance categories: quality, cost, improvement activities, and Promoting Interoperability. The performance categories have different "weights" and the scores from each of the performance categories are added together, resulting in a MIPS Final Score. The MIPS payment adjustment assessed for MIPS eligible clinicians is based on the MIPS Final Score. For the 2026 performance period, the weights for the quality and cost performance categories are 30% each, the weight for the improvement activities category is 15%, and the weight for the Promoting Interoperability category is 25%.

2. What is the MIPS Call for Cost Measures?

The "Call for Cost Measures" process provides interested parties with an opportunity to identify and submit measures for CMS to consider whether to use them in the MIPS cost performance category. Interested parties include:

- Clinicians
- Professional associations and medical societies that represent eligible clinicians
- Researchers
- Consumer groups
- Other interested parties

CMS encourages all interested parties to submit cost measures through the pre-rulemaking process described in Question 3 for consideration during this period. The timeframe for measures to be considered for inclusion on the annual list of cost measures is a 2-year process. Only cost measures submitted via the CMS Measures Under Consideration Entry/Review Information Tool (MERIT) will be considered for inclusion on the annual list of cost measures for the 2028 performance period.

While interested parties were previously able to submit cost measures through the pre-rulemaking process, the MIPS Annual Call for Cost Measures provides interested parties with more guidance about measurement priorities and requirements. This process was established through the Calendar Year (CY) 2022 Physician Fee Schedule (PFS) Final Rule (86 FR 65455). The MIPS Annual Call for Cost Measures has been published annually since 2022 to establish a similar process to the MIPS Annual Call for Quality Measures.

3. How do I submit candidate cost measures for CMS to consider for use in MIPS?

Interested parties responding to the MIPS Annual Call for Cost Measures can submit candidate measures through the pre-rulemaking process. The pre-rulemaking process involves the following steps:

- CMS invites the submission of candidate measures from interested parties through the MIPS Annual Call for Cost Measures. Candidate measures must be submitted to CMS via the CMS MUC Entry/Review Information Tool (MERIT). Measures need to be fully specified and tested for reliability and validity to be considered for use. For more information on measure submission and the pre-rulemaking cycle, please refer to the CMS Measures Management System (MMS) Hub and the CMS Pre-Rulemaking website.[1].CMS publicly releases the Measures Under Consideration (MUC) List no later than December 1 each year.

[1] CMS, Pre-Rulemaking.

- The Consensus-Based Entity (CBE) convenes multi-stakeholders to review measures on the MUC List. The review of measures on the MUC List generally occurs in December after the publication of the MUC List and January of the following calendar year, in which the multi-stakeholders convened by the CBE provide input on measures being considered for use in public reporting and performance-based programs.
- When interested parties submit measures that don't make the MUC List, they or their point of contact will be contacted regarding such status. The notice will outline the reasons why the measure is not recommended for review by the multi-stakeholders convened by the CBE. If it is recommended that the measure be revised and resubmitted, the interested parties can resubmit the measure during a subsequent Call for Cost Measures cycle.
- The multi-stakeholders convened by the CBE provide their recommendations to CMS by February 1 on whether the measures under consideration should be used in various programs.
- CMS considers the input provided by the multi-stakeholders convened by the CBE in selecting measures to propose for use in a Medicare program in a notice of proposed rulemaking in the Federal Register. This allows for public comment and further consideration before a final rule is issued by November 1 of the year before the first day of a performance year.

Cost Performance Category

4. What are cost measures?

Cost measures assess the amount of Medicare spending, usually in dollars, related to providing and receiving medical care. Costs can include the direct costs of treatment, the total costs borne by a patient across all providers, follow-up care, outcomes after treatment, or some mixture of these.

There are different types of cost measures. Section 1848(r) of the Social Security Act, as added by section 101(f) of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 requires the development of episode-based cost measures that take into consideration patient condition groups and care episode groups ("episode groups"), which serve as units of comparison.[2]

There are 33 episode-based measures in the MIPS cost performance category for the 2026 performance period, which represent various types of care episode and patient condition groups. Specifically, they cover:

- Care episode groups, defined to focus on:
  - Procedures of a defined purpose or type. These can be performed in different settings depending on the specific measure's intended focus (e.g., outpatient, inpatient).
  - Acute inpatient medical conditions involving a hospital stay. These can represent treatment for a self-limited acute illness or treatment for a flare-up or an exacerbation of a condition.
- Patient condition groups, defined to focus on:
  - Chronic or long-term health conditions that can involve ongoing management and care.
- Care setting groups, defined to focus on:
  - Care provided in a specific setting (e.g., emergency department).

[2] Care episode groups consider the "patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization occurs, and the principal procedures or services furnished." Patient condition groups consider the "patient's clinical history at the time of a medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history."

There are also 2 global or population-based cost measures in the MIPS cost performance category. These focus broadly on inpatient care and primary care. These are the Medicare Spending Per Beneficiary (MSPB) – Clinician and Total Per Capita Cost (TPCC) measures.

5. How are cost measures selected for MIPS?

CMS reviews submissions to consider whether measures should be included on the MUC List. This process includes consideration of whether the submitted measure has complete specifications and required testing information. In addition, CMS considers how the submitted measure would potentially fit within the MIPS cost performance category and furthers the goals of CMS's Meaningful Measures Initiative. An aspect of this is that a measure should not be duplicative or redundant with an existing cost measure.
In addition, CMS will consider the following factors:

- Is the measure based on measure specifications that have clinical face validity? Are the specifications consistent with practice standards?
- Does the measure have clear, ex ante attribution to clinicians? Could clinicians anticipate when their responsibility for a patient begins under the measure?
- Does the measure include the cost of services that reflect the role of attributed clinicians?
- Is the construction methodology readily understandable to clinicians?
- Can the measure be presented in a way that conveys clear information on how clinicians can alter their practice to improve measured performance?
- Do the measure specifications allow for consistent calculation and reproducibility using Medicare claims data?
- Does the testing information in the submission demonstrate variation to help distinguish cost performance across individual clinicians?
- Can the measure be used in an existing or future potential MIPS Value Pathway (MVP) to assess the value of care for a defined clinical topic?

Beyond these factors, CMS will also consider the extent to which the measure shares the same components as current cost measures and any other factors as appropriate. This helps to promote consistency within the MIPS cost performance category. The MIPS cost measures share the following features: (i) define episodes based on medical codes that determine the patient cohort and identify a clinician-patient relationship for the particular type of care being assessed (i.e., attribution), (ii) specify what costs are included in the measure, (iii) apply exclusions to ensure completeness of data and a fairly comparable patient cohort, and (iv) use a risk adjustment approach to account for differences in clinical and other risk factors that affect cost.

6. Which cost measures are currently in MIPS?

For the 2026 performance period, there are 35 cost measures, as listed in Table 1 below. CMS is the measure steward for these measures.

Table 1. Cost Measures in MIPS

ISO	Cost Measure	Type of Cost Measure	First Year of Use
1	Total Per Capita Cost	Population-based (primary care)	2017; refined measure from 2020
2	Medicare Spending Per Beneficiary Clinician	Population-based (inpatient care)	2017; refined measure from 2020
3	Elective Outpatient Percutaneous Coronary Intervention (PCI)	Episode-based (procedural)	2019
4	Knee Arthroplasty	Episode-based (procedural)	2019

ISO	Cost Measure	Type of Cost Measure	First Year of Use
5	Revascularization for Lower Extremity Chronic Critical Limb Ischemia	Episode-based (procedural)	2019
6	Cataract Removal with Intraocular Lens (IOL) Implantation	Episode-based (procedural)	2019; revised measure from 2025
7	Screening/Surveillance Colonoscopy	Episode-based (procedural)	2019
8	Intracranial Hemorrhage or Cerebral Infarction	Episode-based (acute inpatient medical condition)	2019
9	Inpatient Percutaneous Coronary Intervention (PCI)	Episode-based (acute inpatient medical condition)	2019; revised measure from 2025
10	Acute Kidney Injury Requiring New Inpatient Dialysis	Episode-based (procedural)	2020
11	Elective Primary Hip Arthroplasty	Episode-based (procedural)	2020
12	Femoral or Inguinal Hernia Repair	Episode-based (procedural)	2020
13	Hemodialysis Access Creation	Episode-based (procedural)	2020
14	Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Episode-based (acute inpatient medical condition)	2020
15	Lower Gastrointestinal Hemorrhage *(at group level only)*	Episode-based (acute inpatient medical condition)	2020
16	Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Episode-based (procedural)	2020
17	Lumpectomy, Partial Mastectomy, Simple Mastectomy	Episode-based (procedural)	2020
18	Non-Emergent Coronary Artery Bypass Graft (CABG)	Episode-based (procedural)	2020
19	Renal or Ureteral Stone Surgical Treatment	Episode-based (procedural)	2020
20	Melanoma Resection	Episode-based (procedural)	2022
21	Colon and Rectal Resection	Episode-based (procedural)	2022
22	Sepsis	Episode-based (acute inpatient medical condition)	2022
23	Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Episode-based (chronic condition)	2022
24	Diabetes	Episode-based (chronic condition)	2022
25	Psychoses/Related Conditions	Episode-based (acute inpatient medical condition)	2024
26	Emergency Medicine	Episode-based (setting)	2024
27	Low Back Pain	Episode-based (chronic condition)	2024
28	Heart Failure	Episode-based (chronic condition)	2024
29	Depression	Episode-based (chronic condition)	2024
30	Chronic Kidney Disease (CKD)	Episode-based (chronic condition)	2025
31	End-Stage Renal Disease (ESRD)	Episode-based (chronic condition)	2025
32	Rheumatoid Arthritis	Episode-based (chronic condition)	2025

ISO	Cost Measure	Type of Cost Measure	First Year of Use
33	Prostate Cancer	Episode-based (chronic condition)	2025
34	Kidney Transplant Management	Episode-based (chronic condition)	2025
35	Respiratory Infection Hospitalization	Episode-based (acute inpatient medical condition)	2025

Cost Measure Development

7. Is CMS considering additional cost measures for future use?

Yes, as listed below in Table 2, CMS is considering the Parkinsonism Syndromes and Multiple Sclerosis (MS), Non-Pressure Ulcers, and Breast Cancer Screening cost measures for future use. CMS has contracted with a measure development contractor to conduct additional development of cost measures. Further information will be shared on the CMS QPP Cost Measure Information page as it becomes available. For updates about the process please subscribe to the CMS email list.

Table 2. Current Cost Measure Development, Testing, and Maintenance

ISO	Cost Measure	Status
1	Parkinsonism Syndromes and Multiple Sclerosis (MS)	In Development
2	Non-Pressure Ulcers	In Development
3	Breast Cancer Screening	In Development

The measures in Table 2 were selected with input from interested parties based on the following prioritization criteria and an assessment of measurement gaps:

- The clinical coherence of measure concept to ensure valid comparisons across clinicians.
- The impact and importance to MIPS, including cost coverage, clinician coverage, and patient coverage.
- The opportunity for performance improvement.
- The potential alignment with quality measures and improvement activities to ensure meaningful assessments of value.

8. What is the difference between this MIPS Annual Call for Cost Measures and CMS's own measure development process?

Interested parties who submit a measure in response to the MIPS Annual Call for Cost Measures undertake all steps of measure development and testing themselves. They would then present a fully developed and tested measure for CMS to consider for use in MIPS. The interested party would be the measure steward; this means that the interested party would own the measure and be responsible for determining the measure specifications and for conducting measure maintenance. In contrast, CMS's cost measure development process involves a development contractor who gathers stakeholder input and conducts all measure testing. For those measures, CMS is the measure steward.

9. Do I need to follow a particular process to develop a cost measure?

CMS encourages measure developers who do not currently hold CMS contracts to use the information outlined in each section listed under the Blueprint Measure Lifecycle tab on the CMS Measures Management System (MMS) Hub (content previously found in the CMS MMS Blueprint) as a guide in their measure development process, especially if they have a future interest in working within CMS programs. The Blueprint process produces high-caliber measures that stand up to review for reliability, validity, and importance.

10. Can I access claims data to develop a cost measure?

The new process for cost measure development by interested parties is intended to align with the process that has been available to developers of quality measures. To support cost measure development, interested parties can access publicly available data, such as the Physician and Other Supplier Public Use Files (Physician and Other Supplier PUFs), on Data.CMS.gov.

In addition, measure developers may request restricted data through the CMS Research Data Request process. The process for requesting CMS data for research purposes varies depending on the privacy level and type of data requested. Information on available Limited Data Sets (LDS) and instructions for requesting these data can be found on the CMS LDS website.[3] CMS's Research Identifiable Files (RIFs) are requested through the CMS Research Data Assistance Center (ResDAC).[4] This website contains information on available RIF data and the process for requesting these data can be found. Please note that fees associated with requesting and accessing research data files will be assessed and must be collected prior to CMS providing access to either LDS or RIF datasets.

11. What types of cost measures need to be developed?

We have conducted empirical analyses as part of a scan to identify measurement gaps by specialty. We encourage interested parties interested in measure development to consider the factors listed above under Questions 5 and 7 to identify performance gaps and opportunities for improvement in clinical topics that could apply to their and other specialties. In addition, we identify high priority MVP areas which may benefit from episode-based measures.

Specialties with Limited Episode-based Cost Measures

Based on empirical analyses using administrative claims data, we identified a list of specialties where the current MIPS episode-based cost measures and CMS's measures under development have limited applicability.

While the global cost measures may apply to these specialties, we nonetheless include the specialties here as many interested parties have expressed interest in having measures focused on particular types of care in addition to the broad, population-based measures. The specialties that have clinical topics as part of CMS's Wave 7 development prioritization are indicated with an asterisk (*).

- Anesthesiology
- Audiology
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)
- Dentistry
- Dental Anesthesiology
- Diagnostic Radiology*
- Maxillofacial Surgery
- Medical Genetics and Genomics
- Nuclear Medicine
- Obstetrics/Gynecology*
- Optometry
- Oral Surgery (dentists only)
- Pathology
- Registered Dietician/Nutrition Professional
- Speech Language Pathology

[3] CMS, Limited Data Set Files.
[4] CMS, ResDAC.

Within each specialty, there may be multiple clinical topics; for example, obstetrics and gynecology could include screening for breast cancer, providing care related to menopausal management, and performing surgeries, such as hysterectomies. There may also be clinical topics that involve multiple specialties. For instance, screening for female preventive health (e.g., screening Papanicolaou (Pap) tests and pelvic exams) could involve obstetrics/gynecology, family medicine, internal medicine, and other specialties.

High Priority MVP Clinical Topics

CMS has identified high priority clinical topics for future MVP development described further in MVP Needs and Priorities in the MVP Candidate Development & Submission page.[5] These are also listed in Table 3, below, along with information about potential applicability of episode-based cost measures currently in use in MIPS or under development. The measures not yet included in MIPS are marked with an asterisk (*).

Interested parties may use this information to identify whether additional episode-based cost measures would benefit the MVP clinical topic based on their expertise and understanding of value improvement opportunities and quality metrics that could pair with cost measures within each topic. We note that the MSPB Clinician and TPCC measures could also apply to these clinical topics, but for the purposes of this document have focused just on episode-based measures.

Table 3. High Priority MVP Clinical Topics

ISO	Specialties/ Clinical Topics	Episode-based Cost Measures
1	Allergy/Immunology	• Asthma/Chronic Obstructive Pulmonary Disease (COPD)
2	Endocrinology	• Diabetes
3	Hospitalists	• Inpatient COPD Exacerbation • Intracranial Hemorrhage or Cerebral Infarction • Lower Gastrointestinal Hemorrhage • Sepsis • Emergency Medicine • Psychoses/Related Conditions • Respiratory Infection Hospitalization • Inpatient (IP) Percutaneous Coronary Intervention (PCI)
4	Plastic Surgery	• Melanoma Resection • Emergency Medicine • Non-Pressure Ulcers
5	Speech Language Pathology	• n/a

[5] CMS, 2026 MVP Needs and Priorities.

12. Where can I learn more?

Contact the Quality Payment Program by e-mailing QPP@cms.hhs.gov, creating a QPP Service Center ticket, or calling 1-866-288-8292 (Monday through Friday, 8 a.m. - 8 p.m. ET).
People who are deaf or hard of hearing can dial 711 to be connected to a TRS Communications Assistant

The following resources provide additional information:

- Quality Payment Program Resource Library
- CMS Pre-Rulemaking Website
- CMS Call for Measures Website
- CMS Measures Management System Blueprint
- CMS Meaningful Measures Hub
- 2026 MIPS Summary of Cost Measures
- 2026 MIPS Cost Measure Information Forms
- 2026 MIPS Cost Measure Codes Lists