



Merit-based Incentive Payment System (MIPS) Cost Performance Category Fact Sheet

Purpose

To provide MIPS eligible clinicians and their representatives with an introduction to the MIPS cost performance category.

In this fact sheet, you'll find:

- [Cost Overview](#)
- [Key Terms](#)
- [Reporting Requirements](#)

Cost Overview

Why Is the Cost Performance Category Important?

The cost performance category, alongside the other MIPS performance categories, is intended to reward clinicians for providing high-quality care to patients while reducing unnecessary costs to Medicare. Cost performance can inform clinicians on costs related to managing certain conditions during a defined period, an inpatient hospitalization, a procedure, care received in a particular setting, and overall cost of care delivered to a patient. Cost efficiency **isn't** cutting corners with the quality of care you provide your patients. For example, this performance category may reward care coordination, which can reduce costs by preventing duplicative services and readmissions.

What Is the Cost Performance Category?

- The cost performance category evaluates how your costs compare to other MIPS eligible clinicians. Each cost measure is scored such that:
 - Clinicians whose average costs equal the national median cost for that measure receive a MIPS score equivalent to the MIPS performance threshold.
 - Clinicians whose average costs are below this median receive a higher MIPS score.
 - Clinicians whose average costs exceed this median receive a lower MIPS score.

To account for patient characteristics outside of clinicians' influence, cost measures are risk adjusted to account for factors such as patient age, comorbidities, and other factors. Additionally, certain exclusions are applied to cost measures for factors that can't be accounted for through risk adjustment. Episode-based

cost measures only measure the cost of services clinically related to the measure.¹ Administrative claims data is used to attribute patients to clinicians and to calculate average costs and their corresponding MIPS scores, so you don't need to submit any data for this performance category.

Beginning with the 2026 performance period, there will be a 2-year informational-only feedback period for new cost measures, where clinicians will receive feedback on their measure performance, but the measures won't count towards their cost category score or MIPS final scores.

Key Terms

- **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 4 types of episode-based MIPS cost measures are:
 - **Acute inpatient medical condition episode-based measures.** Acute inpatient medical condition episode-based measures assess the cost of care clinically related to specific acute inpatient medical conditions provided during an episode’s timeframe.
 - **Procedural episode-based measures.** Procedural episode-based measures assess the cost of care that’s clinically related to a specific procedure provided during an episode’s timeframe.
 - **Chronic condition episode-based measures.** Chronic condition episode-based measures assess the cost of care clinically related to the care and management of patients’ specific chronic conditions provided during a total attribution window divided into episodes.
 - **Care setting episode-based measures.** Care setting episode-based measures assess the cost of care provided in a specific setting (e.g., emergency department) and clinically related care provided in that setting during an episode’s timeframe.
- **Total Per Capita Cost (TPCC) measure.** A population-based, all-cost measure that assesses the overall cost of care delivered to a Medicare patient with a focus on the primary care received.
- **Medicare Spending Per Beneficiary (MSPB) Clinician measure.** The MSPB Clinician measure assesses the cost of care for services related to a qualifying inpatient hospital stay (immediately prior to, during, and after) for a Medicare patient.
- **Attribution.** Attribution determines which clinician(s) and clinician group(s) will be assessed on costs of care for a given patient or episode.
- **Risk adjustment.** Risk adjustment accounts for patient-level risk factors that can affect medical costs, regardless of the care provided.
- **Payment (price) standardization.** Payment (price) standardization is the process of calculating standardized claim payment amounts that allow for the measurement and analysis of provider resource use by CMS and researchers.
- **Medicare allowed amount.** A Medicare allowed amount is an allowed charge for a single service. Medicare allowed amounts include Medicare trust fund payments, payments from third-party payers, and beneficiary deductibles and coinsurance.

¹ [2026 Summary of Cost Measures \(PDF, 469KB\)](#)

Reporting Requirements

Cost measures are calculated using Medicare administrative claims data, which means you don't have to submit any data for this performance category when reporting [traditional MIPS](#) or [MIPS Value Pathways \(MVPs\)](#). The [Alternative Payment Model \(APM\) Performance Pathway \(APP\)](#) doesn't measure cost performance.

| Traditional MIPS The original MIPS reporting option. | APP A streamlined reporting option for MIPS APM participants that focuses on primary care. | MVPs The newest MIPS reporting option. Each MVP includes a limited number of connected measures and activities that are relevant to a specialty or medical condition. |
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| Data submission isn't required. Clinicians and groups will be scored on all cost measures for which they meet or exceed the case minimum. | The APP doesn't measure cost performance. | Data submission isn't required. Each MVP assesses performance on specific cost measures for which clinicians and groups meet or exceed the case minimum. For a description of which cost measures are included in each MVP, please see the Explore MIPS Value Pathways (MVPs) webpage. |

Where Can You Go for Help?

Contact the Quality Payment Program (QPP) Service Center by emailing 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). Please consider calling during non-peak hours, before 10 a.m. and after 2 p.m. ET. People who are deaf and hard of hearing can dial 711 to be connected to a TRS Communications Assistant.

Visit the [Quality Payment Program website](#) for other [help and support](#) information, to learn more about [MIPS](#), and to check out the resources available in the [Quality Payment Program Resource Library](#).