Moving Physicians to Value-Based Care

Merit-based Incentive Payment System (MIPS) Legislative Improvements

By replacing the current tournament model of payment adjustments with a more sustainable approach tied to annual payment updates, incentivizing CMS to share data with physicians, and improving the underlying measures, this legislation would transform MIPS into a workable program aimed at improving patient care and reducing avoidable costs. As such, this legislation would also rename the program as the Medicare Physician Data-Driven Performance Payment System (DPPS). Most of the provisions are written to take effect in payment year 2027, which corresponds to performance year 2025. Specifically, DPPS would:

1. **Address Steep Penalties that are Distributed Unevenly**

Problem: Following a five-year interruption to the program due to COVID-19 and the Change Healthcare cyberattack, MIPS now subjects physicians to penalties of up to nine percent unless they meet onerous program requirements. Small, rural, and independent practices, along with practices that care for historically minoritized and marginalized patients, are more likely to be penalized, whereas large group practices, integrated systems, and alternative payment model participants are more likely to receive bonuses. The 2022 Quality Payment Program Experience Report shows that 27% of small practices, nearly 50% of solo practitioners, and 18% of rural practices received a MIPS penalty.

DPPS solution:

- Freeze the performance threshold for at least three years to prevent steep penalties and allow practices to continue to recover from the effects of the pandemic and cyberattack and transition back to MIPS. Importantly, this would also allow CMS time to implement and educate practices on these legislative improvements to the program. GAO would conduct a study about alternative threshold approaches.
- Eliminate the unsustainable MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to their annual payment update (e.g., the percentage increase in MEI), creating more alignment across Medicare payment programs.
- Reinvest penalties in bonuses for high performers, as well as investments in quality improvement and APM readiness aimed at assisting under-resourced practices with their value-based care transformation, with any funds available to small practices, rural practices, and practices that care for underserved, minoritized, or marginalized patients.

2. **Prioritize Timely and Actionable Data**

Problem: Though MACRA requires timely feedback and consultation with stakeholders, there are no enforcement mechanisms to accomplish these provisions. CMS has not met its statutory obligation[1] to provide timely (e.g., quarterly) MIPS feedback reports and Medicare claims data to physicians. Instead, CMS issues a single feedback report after the performance period, up to 18 months after applicable services and care were provided.

DPPS solution: Hold CMS accountable for fulfilling its statutory obligations by exempting from DPPS penalties any physicians who do not receive at least three quarterly data reports during the relevant performance period. Having these reports is critical for the program to work as it is intended so that physicians can monitor their ongoing performance and identify gaps or variations in care that can be used to improve quality of care, care outcomes, and reduce costs.

3. **Be More Clinically Relevant and Less Burdensome**

Problem: It is extremely burdensome and costly to participate and do well in MIPS. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. This high entry barrier is a fundamental reason why less-resourced practices including small, rural, and safety net practices historically do worse in the program. MIPS does not prepare physicians to move to an APM and has not been shown to improve clinical outcomes. Worse, a 2022 study in JAMA found MIPS scores are inconsistently related to performance, which "suggests that the MIPS program is approximately as effective as chance at identifying high vs low performance."

DPPS solution:

- Remove siloes between the four performance categories to maintain accountability while reducing burden.
- Bring the program into alignment with other CMS value-based programs to better align with and support care provided in hospitals and other care settings.
- Recognize the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via "yes/no" attestation of using CEHRT or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means. Participation in a qualifying registry would automatically count toward fulfilling improvement activities.
- Enhance measurement accuracy and clinical relevance, particularly within the cost performance category, to better target variability that is within the physician's ability to influence. It is also important that CMS provide sufficient opportunity for testing and data collection prior to tying new or substantively revised cost measures to physicians' payment. This would require CMS to introduce new or substantively revised cost measures on an information-only basis for at least two years.
- Align cost and quality goals. There is an assumption that MIPS evaluates quality and cost on the same patients and for the same conditions, but this is rarely true. Quality and cost measures are developed in isolation of one another and use different patient

[1] §42 USC 1395w-4(q)(12) requires the Secretary to provide timely (e.g., quarterly) MIPS quality and resource use feedback, as well as claims data feedback about items and services furnished to patients of a MIPS eligible professional by other providers and suppliers, similar to the types of data provided to Medicare Shared Savings Program accountable care organizations.

populations, attribution methodologies, and risk adjustment methodologies. GAO would report on these gaps and whether harmonizing these measures would better ensure that physicians are being measured accurately on the care they provide, and that Medicare beneficiaries are receiving high-value care.

- Improve quality measurement accuracy by incentivizing physicians to test new or significantly revised measures, including QCDR measures, or measures reported using a MIPS collection type (e.g., electronic clinical quality measures) that are being used by a particular physician, group, or ACO, for the first time, by awarding pay-for-reporting credit for three years.

Figure A. Comparison of MIPS and DPPS

	MIPS	Data-Driven Performance Payment System (DPPS)
Performance threshold	The performance threshold is set at the mean or median. Physicians who score between zero points and the performance threshold are penalized, while physicians who score between the performance threshold and 100 points receive a bonus. In 2024, the performance threshold is 75 points.	Congress would freeze the performance threshold at 60 points for the 2025, 2026, and 2027 performance periods while physicians recover from the COVID-19 pandemic, Change Healthcare cyberattack, and CMS implements legislative improvements to the program. This is consistent with the 2021 performance threshold, which was set based on the transitional policies of MIPS and should continue to apply as the program remains in flux following a 5-year interruption due to COVID-19 and subsequent disruption by the cyberattack. There is an option for the Secretary to extend the performance threshold freeze at 60 points beyond the 2027 performance period. For the 2028, 2029, and 2030 performance periods (or, if the Secretary extends the period of the freeze at 60 points, for the 3 years following the last year of such extension), the Secretary shall gradually and incrementally increase the threshold before transitioning to the mean or median.
Threshold reform	Not applicable	GAO must submit a report to Congress and the HHS Secretary in consultation with physician organizations by the end of 2029 which includes detailed recommendations for establishing a replacement performance threshold. If legislation is not enacted to establish a replacement performance threshold within 3 years from the date of the enactment of the DPPS Act, the Secretary is required to promulgate final regulations establishing a replacement performance threshold based on the GAO recommendations.

Payment adjustments	MIPS adjusts physicians' Medicare payments upward or downward by extremely wide margins, ranging from -9% to a hypothetical +27%. Under MACRA, MIPS payment adjustments apply to the physicians' paid amount. For example, in 2024, we understand the maximum increase is 8.25% and the maximum decrease is -9%, which apply on top of the conversion factor cuts that stem largely from budget neutrality requirements.	While budget neutrality would be preserved, DPPS would repeal the tournament model. Instead, payment adjustments would be applied as a percentage to the annual payment update (e.g., 0.25% beginning in 2026 under current law or the increase in MEI under HR 2474). The payment adjustments would apply as follows: • Physicians who score above the performance threshold would receive an increase of one-quarter of the update. • Physicians who score at the performance threshold would receive the annual update. • Physicians who participate but receive a score below the threshold receive a penalty equivalent to one-quarter of the update. • Physicians who do not participate would receive a penalty equivalent to one-half of the update. • A floor of zero would prevent DPPS payment adjustments from imposing negative updates. • The adjustment would not be applied in a year for which the update to the conversion factor is negative. These updates are for one year only. To illustrate, let's say physicians will receive an update tied to inflation in 2027 and the update is 2%. Physicians who score above the performance threshold would receive 2.5%. Physicians who score at the performance threshold would receive a 2% update. Physicians who participate in MIPS but score below the threshold would receive a 1.5% update. Physicians who do not submit any MIPS data would receive a 1% update. All physicians would receive a positive update unlike under current law. As another example, under current law, the update in 2027 is 0.25%. Physicians who score above the performance threshold would receive a 0.3125% update. Physicians who score at the performance threshold would receive a 0.25% update. Physicians who participate in MIPS but score below the update would receive a 0.1875% update. Physicians who do not submit any MIPS data would receive a 0.125% update. All physicians would receive a positive update unlike under current law.

		Finally, in this example, under current law the update in 2025 is 0%. In this scenario, all physicians would receive a 0% update regardless of their performance in MIPS.
Improvement fund	Bonuses are paid based exclusively on MIPS performance. The Small, Underserved, and Rural Support (SURS) technical assistance program ended in 2022 due to lack of funding. It had previously provided support for small practices (fewer than 15 clinicians) and practices in rural locations, health professional shortage areas, or medically underserved areas.	DPPS penalties would fund bonuses to MIPS participants that perform well in DPPS, as well as a new fund for improvement and investments in value-based care, such as data analytic capabilities. CMS would make grants to small, rural, underserved practices and practices with low composite scores for these value-based care funds. Importantly, these investments would also help practices transition to APMs.
Timely and actionable feedback and data	Despite statutory requirements that CMS provide timely MIPS and claims data, physicians received their most recent MIPS Feedback Report, based on 2022 performance, in August 2023. No physician in MIPS has ever received Medicare claims data similar to what MSSP ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. Physicians do not know in real time or even on a quarterly basis which cost measures are being attributed to them, which patients are being assigned to them, and what costs outside of their practice they are being held accountable for until well after the performance year is already over, making it impossible for them to leverage this data to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs.	Physicians who do not receive quarterly feedback reports on administrative claims-based quality and cost measures would be exempt from any DPPS penalty (i.e., any amount below the annual update).
Multi-category credit	MIPS performance is measured across four categories – quality, improvement activities, promoting interoperability (health IT use),	CMS would be required to give automatic credit in each applicable performance category for a measure or activity that satisfies multiple performance category requirements as determined via rulemaking. If

	and cost. Each category has disparate measures, scoring rules, and attribution methods. CMS has informed the AMA that their Office of General Counsel interprets the statute as requiring data submissions in each category, thus preventing automatic or seamless multi-category credit.	a MIPS eligible professional does not report on such a measure or activity for a performance category and automatic application of the measure for that performance category would result in a lower performance score for the professional, then the Secretary would not automatically apply such measure or activity for that performance category.
Expansion of facility-based scoring	Certain MIPS eligible clinicians receive their facility's Hospital Value-Based Purchasing (VBP) Program score for the quality and cost categories without submitting any additional quality measures. To qualify, physicians must furnish 75% or more of their services in a hospital setting (POS codes 21, 22, or 23), bill at least one service in an inpatient hospital or emergency department, and their facility participates in the VBP Program. For groups, 75% of the clinicians billing under the TIN must meet the definition of facility-based.	This bill would allow the Secretary to expand the existing facility-based scoring option by applying scores from hospital outpatient department and other care setting value-based payment programs to all four DPPS categories. Further, CMS would expand the facility-based scoring option to physicians who furnish 50% of their services in facility settings other than the hospital, including ASCs, inpatient psychiatric facilities, and SNFs. Similarly, for groups, 50% of clinicians in the group must meet the definition of facility based.
Clinical data registries and innovative health IT	Despite clinical data registries' proven ability to meaningfully improve patient care and numerous statutory obligations to promote and incentivize the use of clinical data registries, CMS has created numerous obstacles for clinical data registries to succeed within the program and has limited the ability of physicians to leverage their participation in these quality improvement efforts for MIPS. Further, highly prescriptive measures in the PI (health IT) category restrict the program's ability to grow with new technological innovations that drive the industry forward.	CMS would be required to treat physicians who attest to reporting quality measures via clinical data registries as automatically satisfying the requirements of the Promoting Interoperability and Improvement Activities categories. Further, the requirements for the Promoting Interoperability category would be met via "yes/no" attestation of using CEHRT or interacting technology products, participation in a clinical data registry, or other less burdensome means.
Cost measures	CMS continues to use the total per capita cost measure that holds physicians accountable for costs outside of their	By eliminating the requirement that CMS must account for at least one-half of all Parts A and B expenditures with its cost measures and affording CMS the ability to test new cost measures, CMS could

	control. Additionally, CMS develops new episode-based cost measures around costly Medicare conditions despite concerns about access to care (e.g., psychoses) in order to meet statutorily imposed requirement that cost measures must account for at least one-half of Medicare Part A and B expenditures. This forces CMS to develop measures based on volume, rather than based on opportunities to reduce variations in care and produce savings in Medicare. Finally, CMS does not have the authority to test new cost measures before they are used to impact physician payment.	significantly improve the cost category by developing and validating measures that have a potential high impact for change at the physician level. In addition, the requirement to measure total Parts A and B costs would be eliminated. Finally, new and substantively revised cost measures would be informational only for a minimum of two years. Physicians would receive quarterly feedback reports as required above. CMS would be required to provide for a public comment period on the measures that allows for MIPS eligible professionals who are commenters, as applicable, to take into consideration the information they received during the informational period. Then for the measures to be included for assessment and scoring purposes, CMS would propose the measures for inclusion through rulemaking.
Cost and quality measure alignment	MIPS cost and quality measures are not aligned and typically do not reflect the same care provided to the same patients. Physicians may be penalized for providing preventative services, which are important for high quality care, under the Total Per Capita Cost measure, which is a blunt summation of all Medicare Parts A and B spending by a beneficiary during a year. While CMS believes MVPs will solve this issue, they are merely a repackaging of existing measures and do not get at the root cause.	GAO would be required to submit a report to Congress and the HHS Secretary within 12 months of passage of the bill about whether this program incentivizes lower quality to achieve lower costs. Specifically, the study calls for identification of the misalignments, gaps, and other potential causes for such incentives, including that the cost measures are not aligned with the quality measures (e.g., not corresponding to the same conditions or episodes, not applying to the same timeframes, not applying to the same physicians, or not applying to the same panel of patients). GAO would provide recommendations for modifications to eliminate these gaps or misalignments and would identify whether the changes require legislation or regulation.
Quality measures	Investing in new quality measures is extremely costly and time-consuming. Worse, there are disincentives for physicians to use new quality measures in MIPS as they are likely to be scored worse than existing measures with a benchmark. Physicians are inherently taking a risk when reporting any new measure, which hinders the program's ability to continue to grow and adapt into the future.	CMS would be required to incentivize reporting of new and substantively revised quality measures, as well as quality measures without a benchmark and MIPS quality measure collection types that are being used by a physician for the first time, by treating them as pay-for-reporting for three years. In other words, physicians who meet the reporting criteria would automatically receive full credit (e.g., 10 points) for that measure for three years.