Data-Driven Performance Payment System (DPPS):
Solving the Problems with the Merit-based Incentive Payment System (MIPS)

MIPS Background

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 consolidated three historic quality reporting programs into MIPS. MIPS requires physicians to report on quality measures, health IT measures, and improvement activities, creating significant administrative burden. The Centers for Medicare & Medicaid Services (CMS) also calculates cost measures and a new population health category (not-statutorily required) using claims data. CMS combines all of this data and generates a score of 0-100 points. Based on how their score compares to the national benchmark, physicians will see a penalty, a neutral payment adjustment, or a bonus. MIPS adjusts Medicare physician payment for all physicians unless they're new to Medicare, qualifying alternative payment model participants, or have a low volume of Medicare patients or payments. The program is budget neutral. Penalties of up to -9 percent fund the bonuses.

Why are reforms to MIPS necessary?

- **MIPS disproportionately penalizes small and rural practices.** Nearly 50 percent of solo eligible clinicians (ECs), 29 percent of small practices, and 18 percent of rural practices received a MIPS penalty in 2025 compared to fewer than 14 percent of ECs overall. Nearly 30 percent of solo ECs and 13 percent of small practices received the maximum -9 percent penalty compared to 2 percent of ECs overall.
- **MIPS is burdensome and costly.** MIPS compliance costs $12,800 and requires 202 hours per physician per year according to a 2021 Journal of the American Medical Association (JAMA) Health Forum study.
- **MIPS does not measure quality and exacerbates health inequities.** According to a 2022 JAMA study, MIPS scores are approximately as effective as chance in terms of identifying high versus low quality performance. Researchers found physicians providing high quality care but with low MIPS scores tended to have practices catering to a greater number of sicker and lower-income patients.
- **There are too few clinically relevant measures for specialists.** MIPS scoring rules also disincentivize reporting on certain quality measures that are tailored to specialty care.

Introducing DPPS

It has been more than 10 years since MACRA passed, and change is urgently needed to reduce the harmful effects of MIPS. Designed as an alternative to MIPS, DPPS has been endorsed by the AMA, every state medical society, and more than 100 national specialty societies. DPPS would reset Medicare's approach to improving quality and reducing avoidable costs by supporting small, rural and safety net practices; and increasing the clinical relevance of quality and cost measures to physicians and patients.

How does DPPS support small, rural, and safety net practices by reducing steep penalties?

- DPPS would eliminate the win-lose tournament model and reduce the maximum penalty from -9 percent to one-half of a physician's annual payment update (for example, 0.25 percent under current law or the increase in the Medicare Economic Index if H.R. 2474 passes), which is similar to other Medicare programs such as the Hospital Inpatient Quality Reporting Program.
- It would reinvest penalties in quality improvement and alternative payment model readiness by assisting under-resourced practices with their value-based care transformation.
- DPPS would freeze the performance threshold at 75 points for at least three years.

How does DPPS improve the clinical relevance and accuracy of cost and quality measures for physicians and patients?

- DPPS would incentivize CMS to fulfill its statutory obligations to share data on a quarterly basis, enabling physicians to improve performance on quality and cost measures.
- Specifically, physicians who receive fewer than three MIPS performance feedback reports during the performance period would be exempt from any MIPS penalties.
- With quarterly reports about 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, physicians can leverage this data to implement changes that would improve patient care and use resources more efficiently, saving money for the Medicare program, taxpayers, and beneficiaries.