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All Together Better.

Traction and Trends in Value-Based Care

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July 25, 2025

VBC Adoption
CMS Proposed Rule, 2026
VBC Challenges
VBC Opportunities

VBC Adoption

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CMS aims to have all Medicare fee-for-service beneficiaries in a value-based care relationship by 2030

In 2025, 53.4% of Traditional Medicare beneficiaries are already participating in accountable care relationships, a 4.3% increase from the previous year and the largest annual increase since CMS started tracking these numbers.

CMS, 1/25

This includes **476 Accountable Care Organizations (ACOs) in the Shared Savings Program**, representing 11.2 million people with Traditional Medicare.

The **ACO REACH model comprises 103 ACO**s that care for approximately 2.5 million people with Traditional Medicare.

A new model, **ACO PC Flex**, was launched in 2025 with **24 ACO**s covering 349,000 people enrolled in Traditional Medicare.

2023 QPP Participation

	2021	2022	2023
Total number of Advanced APM participants	333,658	420,591	505,210
Total number of QPs	271,231	384,105	463,669
Total number of Partial QPs	3,365	2,528	1,339

Qualifying APM Participants (QPs) receive at least **50%** of Medicare Part B payments OR see at least **35%** of Medicare patients through an Advanced APM Entity

Partial QPs receive at least **40%** of Medicare Part B payments OR sees at least **25%** of Medicare patients through an Advanced APM Entity

2023 MIPS Participation

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Table 1. Overall MIPS Participation

	2021	2022	2023
Number of MIPS Eligible Clinicians (All)	606,863	624,209	541,421
Number of MIPS Eligible Clinicians (Non-Reporting[7])	41,082	36,554	32,631
Percent of MIPS Eligible Clinicians (Non-Reporting)	5.88%	5.86%	6.03%

Table 2. Changes in MIPS Participation

	Change from 2021 to 2022 (Number)	Change from 2021 to 2022 (Percentage)	Change from 2022 to 2023 (Number)	Change from 2022 to 2023 (Percentage)
MIPS Eligible Clinicians (All)	-74,674	-10.68%	-82,788	-13.26%
MIPS Eligible Clinicians (Non-Reporting[7])	-4,528	-11.02%	-3,923	-10.73

Source: QPP Resource Library

2023 MIPS Performance Year

541,421 Total clinicians who will receive a MIPS payment adjustment

32,631 Total non-reporting clinicians (clinicians who didn't submit data) receiving a MIPS payment adjustment[1]

463,669 Total number of QPs[2]

1,339 Total number of Partial QPs[2]

6.03% (Overall) of all clinicians receiving a MIPS payment adjustment were non-reporting (didn't submit data).[1]

26.14% (Small practices) of clinicians in small practices[3] receiving a MIPS payment adjustment were non-reporting (didn't submit data).[1]

50.37% (Solo practitioner) of solo practitioners receiving a MIPS payment adjustment were non-reporting (didn't submit data).[1]

Performance Threshold	Mean Final Score	Median Final Score
75 pts	**83.18 pts** (Overall) **79.96 pts** (Traditional MIPS) **94.35 pts** (APM Performance Pathway) **82.87 pts** (MVPs)	**85.49 pts** (Overall) **82.11 pts** (Tracitional MIPS) **94.62 pts** (APM Performance Pathway) **87.86 pts** (MVPs)

2023 MIPS Scores

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Table 29. 2023 Final Scores and 2025 Payment Adjustments

	Final Score		Payment Adjustment	
Status	**Mean**	**Median**	**Mean**	**Median**
MIPS Eligible Clinicians (All)	83.18	85.49	0.59%	0.90%
MIPS Eligible Clinicians (**Engaged**[36])	85.54	86.59	0.86%	1.00%
MIPS Eligible Clinicians (**Non-Reporting**[40])	46.35	75.00	-3.59%	0.00%

The mean is the average of a set of numbers, found by adding all the values and dividing by the number of values. The median is the middle value in a sorted list of numbers

New Program and Proposed Rule, 2026

2026 TEAM

Transforming Episode Accountability Model (TEAM)

Selected hospitals would be responsible for coordinating the care of Medicare beneficiaries who undergo certain surgical procedures, from the time of surgery until 30 days after the patient leaves the hospital.

“Pave the way for managing episodes as a standard practice in Traditional Medicare”

TEAM is a 5-year program that starts on January 1st, 2026, and ends on December 31st, 2030. Final data submission of clinical data elements and quality measures is in CY 2031

2026 TEAM

Notably, and consistent with the CMS Innovation Center strategy to drive accountable care and ***integrate specialty care and primary care***

The model is designed to complement longitudinal care management through policies that align with Accountable Care Organizations (ACOs) and ***promote primary care referral***.

TEAM Eligible Episodes

1. Coronary Artery Bypass Graft (CABG)
2. Lower Extremity Joint Replacement (LEJR)
3. Major Bowel Procedure
4. Surgical Hip/Femur Fracture Treatment (SHFFT)
5. Spinal Fusion

These episodes represent high-expenditure, high-volume care delivered to Medicare beneficiaries.

TEAM Quality Measures

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Measure title	Eligible Episodes	Performance Years (PY)	Sourced From
Hybrid Hospital-Wide Readmission	All	PY 1-5	Inpatient Quality Reporting (IQR)
Inpatient THA/TKA PRO-PM	LEJR	PY 1-5	Inpatient Quality Reporting (IQR)
PSI 90	All	PY 1	Hospital Acquired Condition Reduction Program (HACRP)
HH-Falls w/ Injury eCQM	All	PY 2-5	Inpatient Quality Reporting (IQR)
HH-Post-Respiratory Failure eCQM	All	PY 2-5	Inpatient Quality Reporting (IQR)
Failure to Rescue Claims	All	PY 2-5	Inpatient Quality Reporting (IQR)
Information Transfer PRO-PM	All	PY 3-5	Outpatient Quality Reporting (OQR)

TEAM Participation Tracks

Track 1 (only available in PY 1)

Track 1 has financial upside only. Hospitals will be rewarded for their work to improve quality and cost outcomes for their episodes, but will not be held financially accountable for poor cost results. Everyone starts in Track 1.

- 10% positive quality score adjustment
- 10% stop-gain limit (applied after quality score adjustment)

Track 2 (available PY 2-5) (limited participants)

Track 2 has two-sided financial risk:

- 10% positive quality score adjustment OR 15% negative quality score adjustment
- 10% stop-gain and stop-loss limits (applied after quality score adjustment)

Participants are limited to Safety Net Hospitals, Rural Hospitals, Medicare Dependent Hospitals (MDH), Sole Community Hospitals (SCHs) or essential access community hospitals.

Track 3 (available PY 1-5)

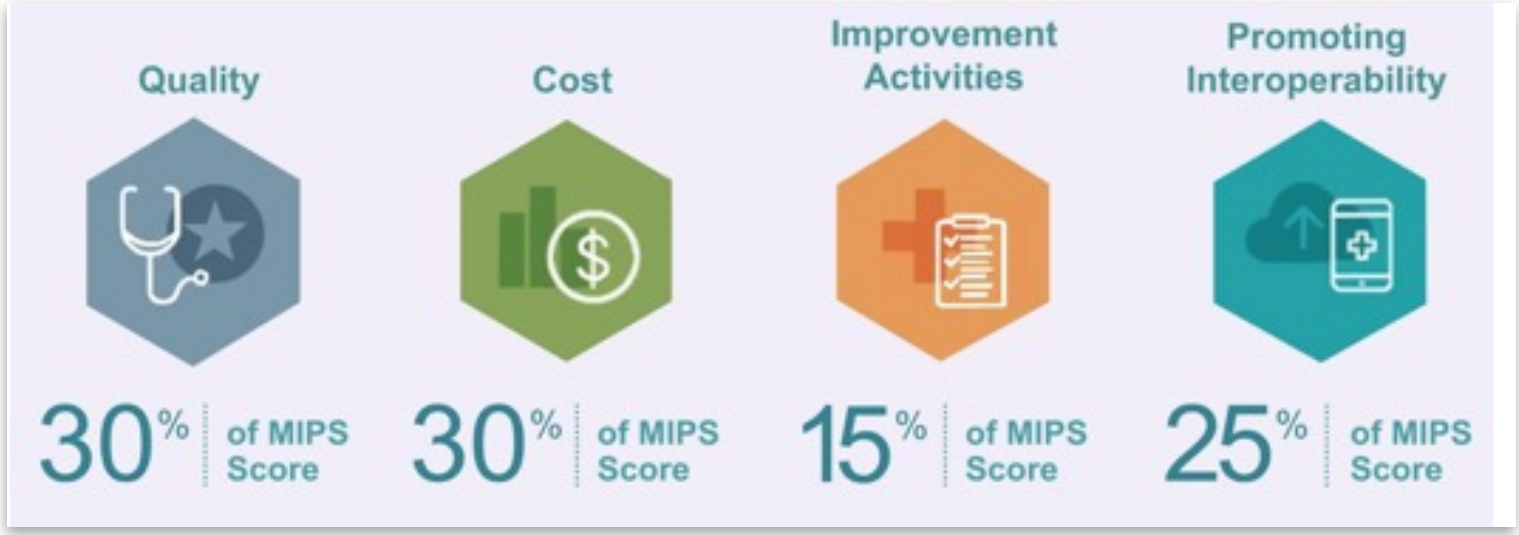
Track 3 has two-sided financial risk:

- 10% positive and negative quality score adjustment and 20% stop-gain and stop-loss limits (applied after quality score adjustment)

Proposed Rule Highlights

MIPS Performance Threshold Held Steady at 75 Points

Category Weights remain unchanged



Proposed Rule Highlights - COST

No expansion/reduction to the existing 35 cost measures

Update candidate event and attribution rules for the Total Per Capita Cost (TPCC) measure.

> CMS proposes to exclude advanced practice non-physician practitioners (NPs, PAs, and CCNSs) from TPCC attribution if they are part of a group where all other clinicians are excluded based on specialty.
>
> This addresses concerns about the inappropriate attribution of specialty groups due to the billing patterns of these practitioners

MVP Highlights

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY
MIPS Value Pathways (MVPs) Development and Strategy		
MVP Development and Maintenance	**MVP Inventory** There are 21 MVPs finalized for reporting in the CY 2025 performance period.	**MVP Inventory** We're proposing to add 6 new MVPs* to the MVP inventory: • Diagnostic Radiology • Interventional Radiology • Neuropsychology • Pathology • Podiatry • Vascular Surgery

MVP Reporting

Policy Area	Existing Policy	Proposed Policy
Subgroup Reporting: Small Practice and Multispecialty Group	Participation Options: Multispecialty groups that want to report an MVP must register at the subgroup, individual, or APM Entity level.	Multispecialty groups that are small practices (15 or fewer clinicians) would still be able to register to report an MVP as a group. Multispecialty groups that are small practices wouldn't be required to register as subgroups if they didn't want to report as individuals.

MVP Reporting

Policy Area	Existing Policy	Proposed Policy
MVP Reporting: Single Specialty Group	Definition/ Determination A single specialty group means a group that consists of one specialty type as **determined by CMS using Medicare Part B claims**.	Groups **would attest to their specialty composition** (whether they're a single specialty or multispecialty group that meets the requirements of a small practice) during the MVP registration process.

Proposed Rule Highlights

19 Measures that belong to Speciality Sets with limited measure choice and many topped out revert to the past benchmark (10 point availability)

Performance Rate	Available Points
84 – 85.9%	1 – 1.9
86 – 87.9%	2 – 2.9
88 – 89.9%	3 – 3.9
90 – 91.9%	4 – 4.9
92 – 93.9%	5 – 5.9
94 – 95.9%	6 – 6.9
96 – 97.9%	7 – 7.9
98 – 98.9%	8 – 8.9
99 – 99.99%	9 – 9.9
100%	10

Improvement Activities Update

POLICY AREA	EXISTING POLICY	CY 2026 PROPOSED POLICY
Improvement Activities Performance Category		
Improvement Activities	**Inventory** There are 104* improvement activities available for the 2025 performance period. *Please note that on May 6, 2025, we announced the suspension of 8 improvement activities for the 2025 performance period.	**Inventory** We're proposing the following changes to the improvement activities inventory for the 2026 performance period: • Addition of 3 new activities (See Appendix D) • Modification of 7 existing activities • Removal of 8 activities (See Appendix E) We're also proposing to remove the Achieving Health Equity (AHE) subcategory for improvement activities and to add the Advancing Health and Wellness (AHW) subcategory to replace it.

Improvement Activities Update

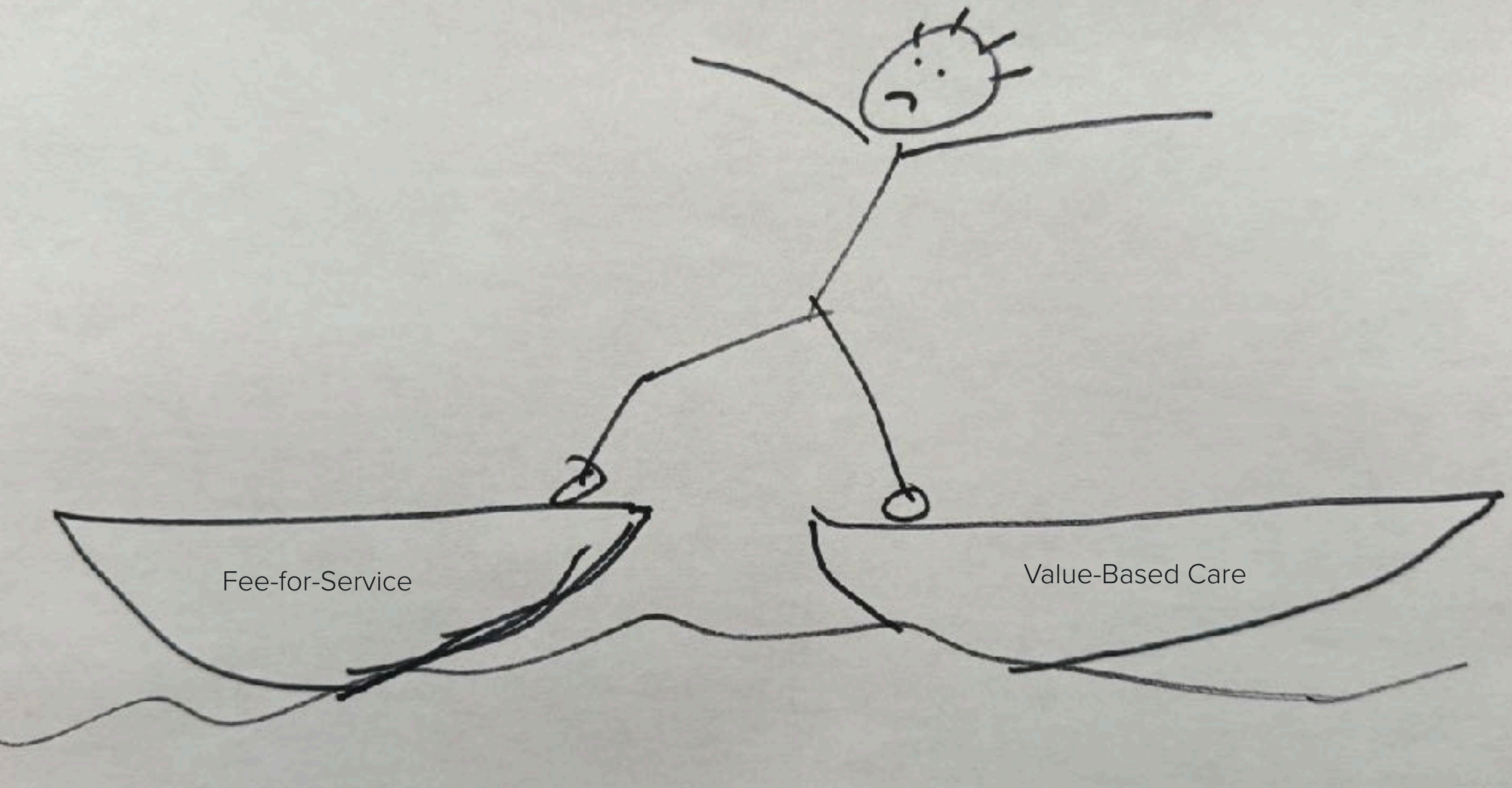
There are several proposed changes to the list of improvement activities (IAs), including:

- 3 proposed new IAs, including Patient Safety in Use of Artificial Intelligence (AI).
- 7 changes proposed to existing IAs (predominantly measure ID changes).
- 8 proposed removals, which are the same as the measures suspended in 2025:
  - AHE_5: MIPS Eligible Clinician Leadership in Clinical Trials or CBPR
  - AHE_8: Create and Implement an Anti-Racism Plan
  - AHE_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
  - AHE_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
  - AHE_12: Practice Improvements that Engage Community Resources to Address Drivers of Health
  - ERP_3: COVID-19 Clinical Data Reporting with or without Clinical Trial
  - PM_6: Use of Toolsets or Other Resources to Close Health and Health Care Inequities Across Communities (Use of toolset or other resources to close healthcare disparities across communities)
  - PM_26: Vaccine Achievement for Practice Staff: COVID-19, Influenza, and Hepatitis B

Traditional MIPS to MVP Transition

Although CMS reiterated its intention to sunset traditional MIPS and transition to mandatory MVP participation, no proposal was included in the rule. Previously, CMS requested feedback on potentially requiring MVP participation as early as 2029

VBC Challenges


Fee-for-Service
Value-Based Care

Clinical processes and infrastructure are designed for a volume-driven, fee-for-service environment

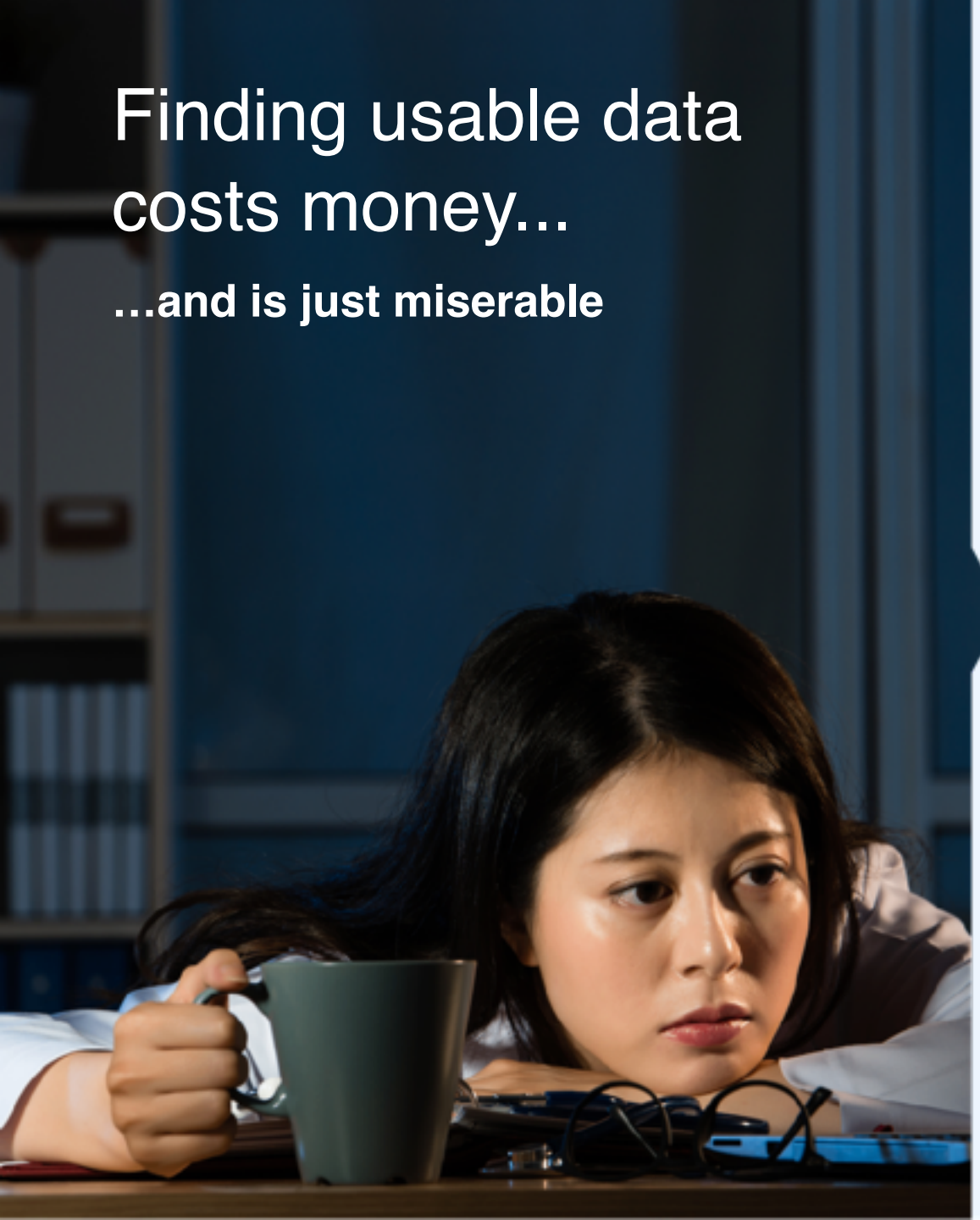
Nearly half—49%—of solo physicians were penalized, as were 29% of small practices and 18% of rural practices.

The administrative complexity and burden that VBC carries can be overwhelming

Multiple changes each year, complex programs from various payers and a lack of information technology support

Finding usable data costs money...

...and is just miserable




The Volume and Cost of Quality Metric Reporting

Preparing and reporting data for these [quality] metrics required an estimated **108,478 person hours**, with an estimated personnel cost of **$5M**


Annals of Internal Medicine

ORIGINAL RESEARCH

Physician Time Spent Using the Electronic Health Record During Outpatient Encounters

A Descriptive Study

Physicians spent an average of **16 minutes and 14 seconds** per encounter using EHRs, **with chart review [accounting for] 33%...**

Value-Based Care programs require data that is typically locked away in scanned documentation and multiple technologies

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Care information is scattered across EHRs, payer portals, PDF clinical notes, and spreadsheets.

EMRs are bloated and getting worse

$30B

US Health spending on EMRs since 2008

53 Notes

Avg number of documents in an EMR per patient

60%

Growth in the size of an average medical chart, 2009 - 2018

Data is being shared but major gaps remain

75%

Share of hospitals participating in at least one health information exchange

35%

Of Medicare patients see five or more physicians for care

34%

Of primary care doctors report missing key data on patients

Better data required for value-based care

55%

Of healthcare spending now tied to some form of value-based payments…

- **Quality Metric Coding/HEDIS**
- **Risk Adjustment** (Disease Burden Coding)
- **Outcomes metrics**
- **Population management data**

Industry Consolidation brings additional VBC complications

Most groups are together in name only, with disparate technology and processes

Ambulatory Surgery Centers help with cost, but often bring complications for VBC programs

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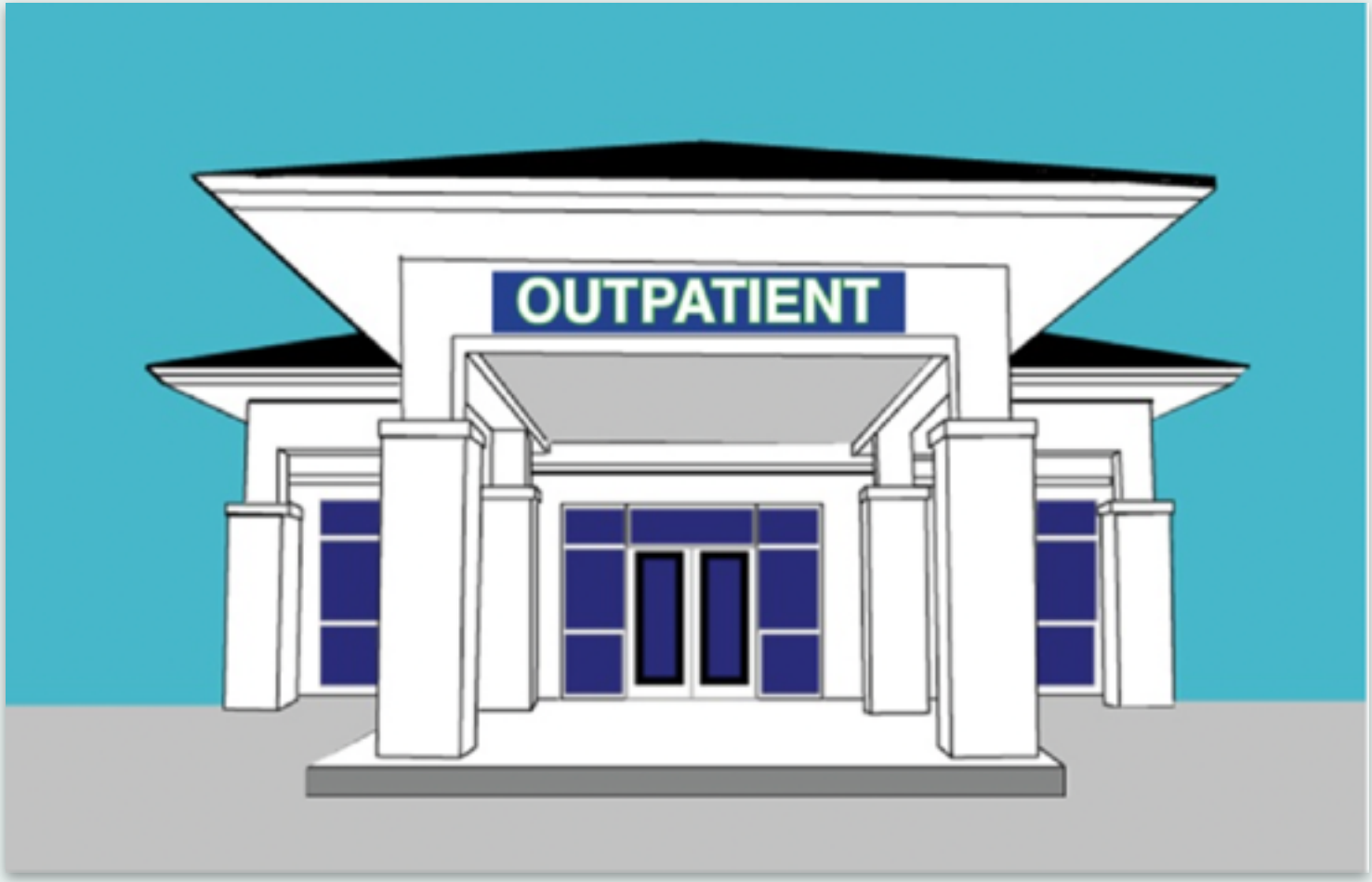
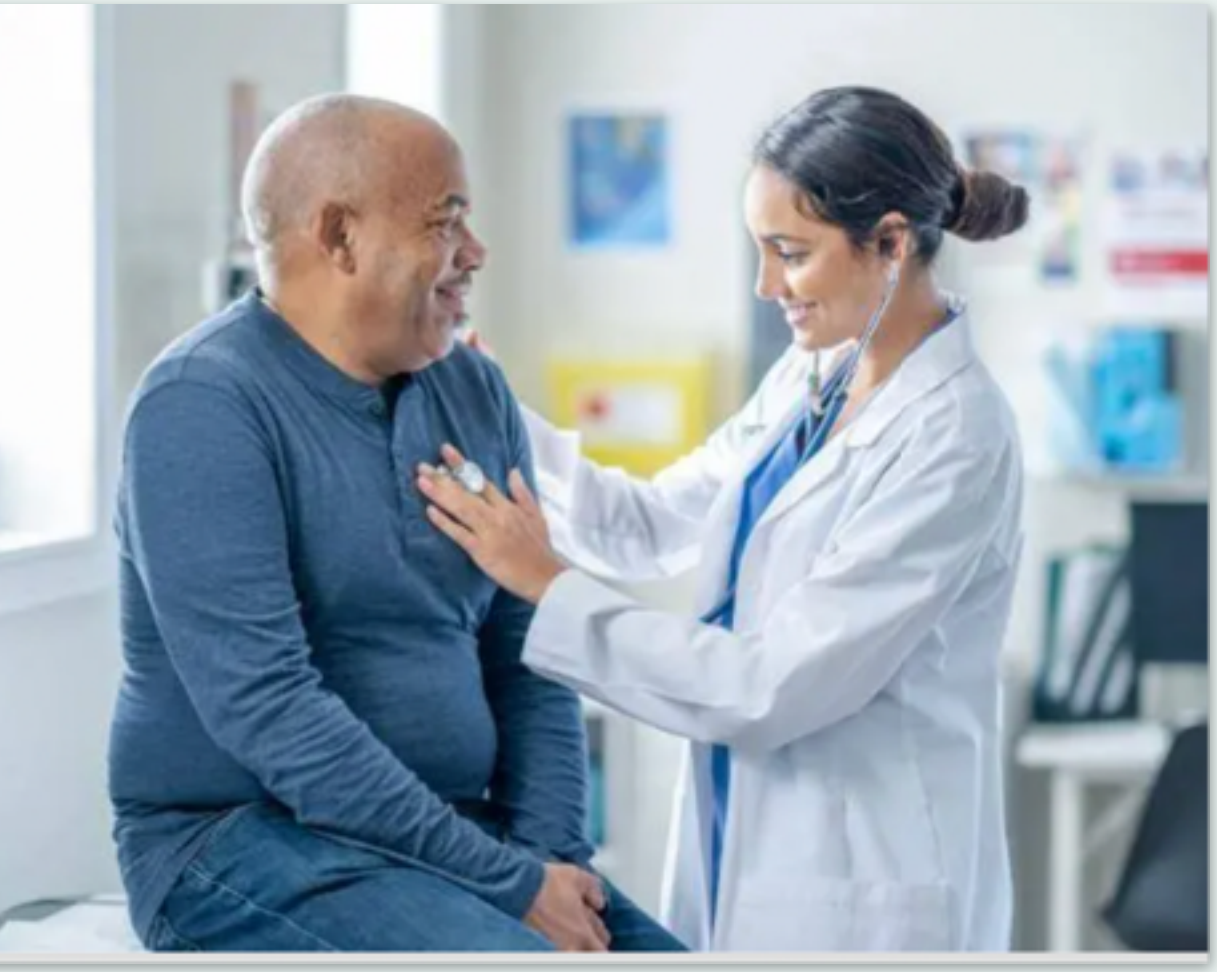
Most are developed with stand-alone technology, making it difficult to reach measure compliance

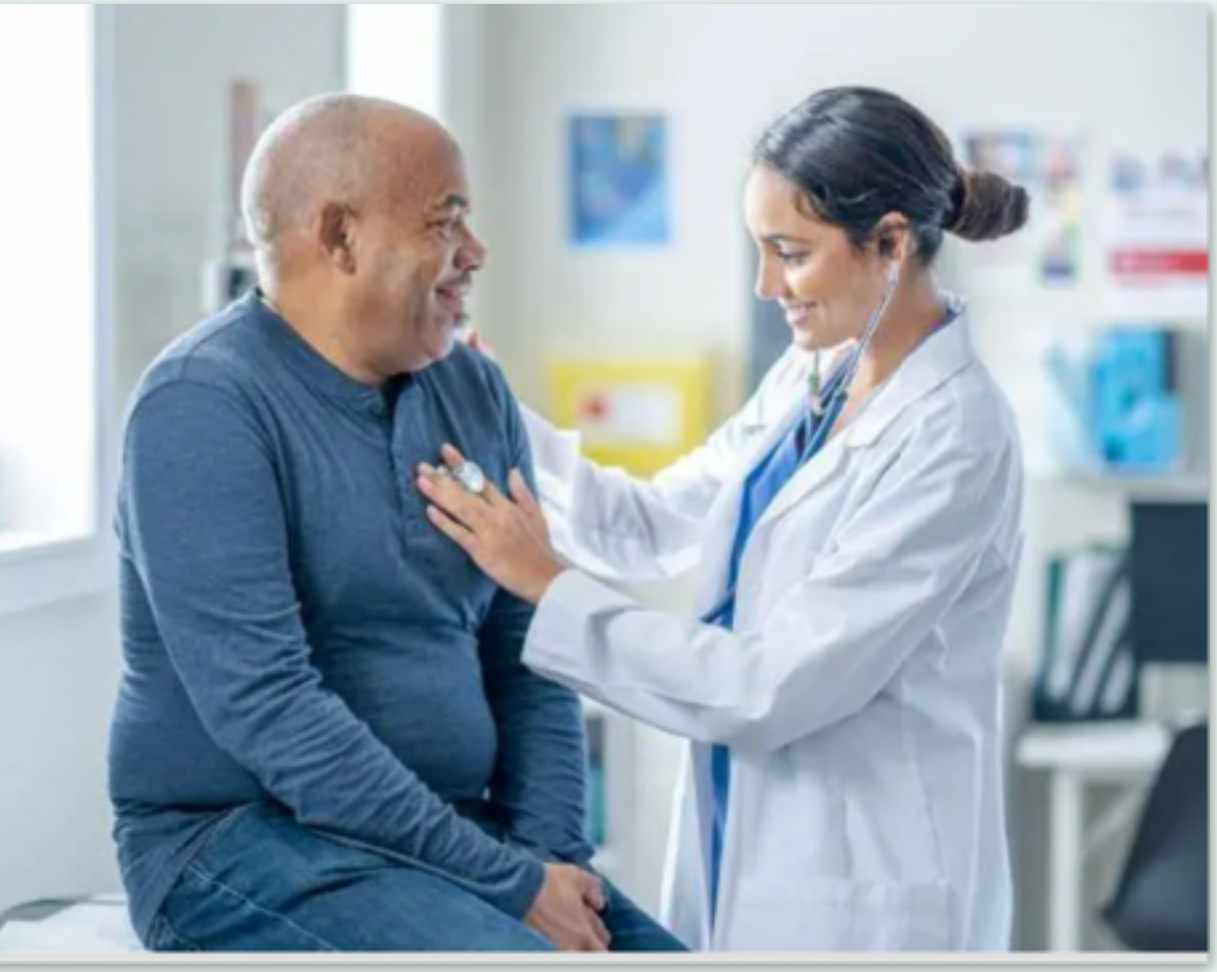


Value-Based Care is a Team Sport



VBC Opportunities

Value-Based Care is a Team Sport



Qualified Registries overcome technology and measure challenges

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a CMS-approved entity that collects clinical data, often to track patient care and disease, and then submits this data to CMS on their behalf.

Qualified Registries overcome technology and measure challenges

KAIDhealth

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Schedule A Demo

Value-Based Coding™

Your single solution for AI-powered medical coding, quality monitoring & clinical analytics.

KAID's Value Based Coding… *AI for Using All EMR Data*

	Failure of Traditional Medical Coding	Value Based Coding™ KAIDhealth
More value	Administrative workflow	Administrative & clinical workflow
Expanded Goals	Only assigns all the correct codes, at best	Assigns all the correct codes Arms care team with actionable insights
New revenue models	Fee-for-service only	Fee-for-service & risk-based combined
Richer Metrics	Revenue capture Coding accuracy Low coding costs	Revenue capture Coding accuracy Low coding costs Quality metric capture Provider efficiency
More Data	Only encounter notes	All medical notes Health Exchange Data EMR structured data Claims data
Underpinning tech	Rules-based systems	Validated, ethical Artificial Intelligence
Engaged Physicians	Limited, transactional, disruptive	Ongoing and appreciated
KEY TO SUCCESS		Great people using best-in-class AI

Patient outcomes data is just the beginning for improving your ROI

- Comprehensive patient intelligence platform
- Patient-reported outcomes + objective clinical + surgical information gathered at every touchpoint
- Visual analyses for easy understanding and interpretation
- Useful for clinicians, physicians, therapists, researchers, marketers, and financial leadership
- Developed since 2009 from more than 100 pioneering patents

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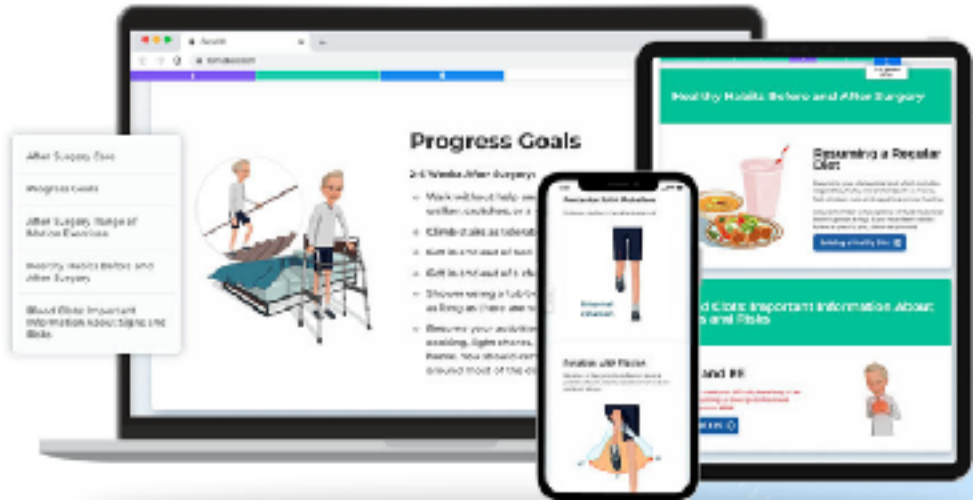
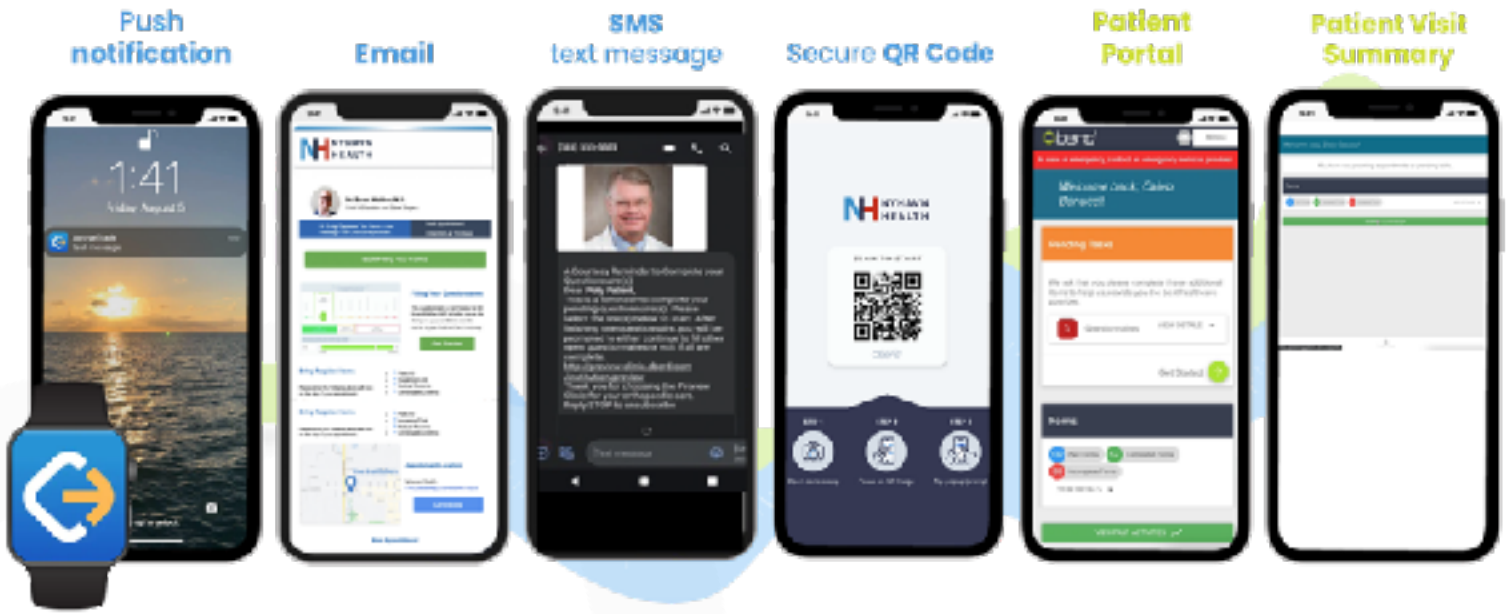
Making PROs Make Sense to Patients

- **Shorter, More Relevant Forms:**
  Adaptive technology tailors questions to patient conditions, reducing burden
- **Improved Understanding = Better Compliance:**
  Patients see how their input informs treatment options
- **Satisfaction Improvement Opportunities:**
  Patients feel heard, understood, and more in control of their care



Empowering Value-Based Care with PROs

- OBERD helps providers and patients **co-navigate care**
- PRO completion: **up to 30 % higher** than industry benchmarks
- Adaptive**, bite sized surveys** with **OBERD CAT**
  - Dynamic logic trims 40-60% of questions; avg. completion < 3 min



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