Quality Payment PROGRAM

2020 Merit-based Incentive Payment System (MIPS) Payment Adjustment Fact Sheet

In July 2019, each MIPS eligible clinician received a 2018 MIPS final score and 2020 MIPS payment adjustment information as part of their performance feedback. The 2020 MIPS payment adjustment, determined by the 2018 final score, will affect payments for services in calendar year 2020, also referred to as the 2020 MIPS payment year.

Who Will Receive a MIPS Payment Adjustment in 2020?

MIPS eligible clinicians, identified by TIN/NPI combination for the 2018 performance period, will receive a MIPS payment adjustment in 2020. Specifically, you will receive a 2020 MIPS payment adjustment in 2020 if, for the 2018 performance period, you:

- Were a clinician type that was included in MIPS; AND
- Enrolled in Medicare prior to January 1, 2018; AND
- Were not a Qualifying APM Participant (QP[1]); AND
- Are not a Partial Qualifying APM Participant (Partial QP) that does not elect to participate in MIPS as a MIPS eligible clinician; AND
- Met **one** of the following criteria:
  - Individually exceeded the low-volume threshold; OR
  - Were in a practice that exceeded the low-volume threshold at the group level **and** submitted group data or were part of an approved virtual group; OR
  - Were in a MIPS APM and the APM Entity group exceeds the low volume threshold (see footnote below; also includes Partial QPs who elected to participate in MIPS)

[1] A QP is an eligible clinician participant in an Advanced APM who is determined by CMS to have met or exceeded the relevant QP payment amount or QP patient count threshold. If you participate in an Advanced APM that is also designated as a MIPS APM **and** you are not a QP, then you will be scored under the APM scoring standard if the APM Entity group exceeds the low volume threshold.

Determining Your 2020 MIPS Payment Adjustment

If you meet the criteria above, your payment adjustment was determined by the final score associated with your TIN/NPI combination. Your final score was compared to performance thresholds to determine whether you will receive a positive, negative, or neutral adjustment to payments for the covered professional services you furnish in the 2020 MIPS payment year.

1. **The performance threshold for the 2020 MIPS payment year is 15 points**—this means a 2018 MIPS final score of at least 15 is required to avoid a negative payment adjustment in the 2020 MIPS payment year.
2. **The additional performance threshold for exceptional performance for the 2020 MIPS payment year is 70 points**. A MIPS eligible clinician with a final score of 70 points or higher will receive an additional payment adjustment factor for exceptional performance.

The MIPS payment adjustment factor(s) are determined by the MIPS eligible clinician's final score. Payment adjustment factors are assigned on a linear sliding scale and are based on an applicable percent defined by law.

Table 1: How 2018 MIPS Final Scores Relate to 2020 MIPS Payment Adjustments

ILLUSTRATION OF POINT SYSTEM AND ASSOCIATED PAYMENT ADJUSTMENTS

FINAL SCORE IN POINTS	0.00-3.75	3.76-14.99	15.00	15.01-69.99	70.00-100.00
MIPS PAYMENT ADJUSTMENT	Negative 5 percent	Negative MIPS payment adjustment greater than negative 5 percent and less than 0 percent on a linear sliding scale.	0 percent adjustment (neutral)	Positive MIPS payment adjustment determined on a linear sliding scale. The adjustment is multiplied by a scaling factor to preserve budget neutrality.	Positive MIPS payment adjustment determined on a linear sliding scale. The adjustment is multiplied by a scaling factor to preserve budget neutrality; PLUS An additional MIPS payment adjustment factor for exceptional performance determined on a linear sliding scale. The additional adjustment is also multiplied by a scaling factor to account for available funds.

A single clinician, identified by NPI, that billed Medicare under multiple TINs during 2018, can receive a separate 2018 MIPS final score for each of his/her unique TIN/NPI combinations.

Such clinicians may receive a different MIPS payment adjustment for covered professional services billed under each associated TIN/NPI combination in the 2020 payment year.

Budget Neutrality and Scaling Factors

MIPS payment adjustments are required by law to be budget neutral, which generally stated means that the projected negative adjustments must be balanced by the projected positive adjustments.

To achieve this, positive MIPS payment adjustment factors (discussed below) may be increased or decreased (or "scaled") by an amount called a "scaling factor." The scaling factor must be a number between 0 and 3, but the exact amount depends on the distribution of final scores across all MIPS eligible clinicians.

- For example, if the scaling factor that is applied to positive MIPS payment adjustment factors is less than 1.0, a clinician who received a final score of 100 points will still receive a positive payment adjustment, but the amount of the positive payment adjustment that clinicians will receive will be less than the applicable percent, which is 5 percent for 2020 (excluding the additional adjustment for exceptional performance).
- Similarly, if the scaling factor is above 1.0, then the amount of the positive payment adjustment for a clinician who received a final score of 100 points will be more than 5 percent for 2020 (excluding the additional adjustment for exceptional performance).

A scaling factor is also applied to the additional adjustments for exceptional performance. In this circumstance, the scaling factor is necessary to proportionally distribute the available funds ($500 million).

Important

Actual 2020 payment adjustments are based on the distribution of 2018 final scores in comparison to the performance thresholds. The modest positive payment adjustment you see is a result of high MIPS participation rates in combination with a high percentage of participating clinicians earning a final score well above the relatively low performance threshold of 15 points. With so many clinicians successfully participating, the distribution of positive adjustments is spread across many more people.

Additional payment adjustment information, such as the range of 2020 payment adjustments, is forthcoming. We anticipate this information will be available after we have finished processing Targeted Reviews. We'll also be providing a comprehensive 2018 MIPS Experience Report in the coming months that documents national trends for MIPS eligibility, participation, and reporting. You can also review information about our initial 2018 participation results in this recent blog post and the 2018 QPP Participation Results Infographic.

Multiple Final Scores for a Single TIN/NPI Combination

In some cases, there may be multiple final scores associated with your TIN/NPI combination. If this happens, we will use the hierarchy described in the table below to assign the final score that will be used to determine your payment adjustment under that TIN/NPI combination.

Table 2: Hierarchy for Assigning the 2018 MIPS Final Score when More Than One Final Score is Associated with a TIN/NPI Combination for a MIPS Eligible Clinician

Scenario	Final Score Used to Determine Payment Adjustments
TIN/NPI is scored under the APM scoring standard and has more than one APM Entity final score.	The highest of the APM Entity final scores.
TIN/NPI has an APM Entity final score and any other final score (individual, group or virtual group).	APM Entity final score.
TIN/NPI has virtual group final score and an individual or group final score.	Virtual group final score.
TIN/NPI has a group final score and an individual final score.	The higher of the two final scores (either group or individual).

Multiple TIN/NPI Combinations/Establishing a New TIN/NPI Combination after the 2018 Performance Period

There may be instances when a MIPS eligible clinician, identified by NPI, billed Medicare under multiple TINs during 2018. In this situation, the clinician can receive a separate 2018 MIPS final score for each of his/her unique TIN/NPI combinations. Such clinicians may receive a different MIPS payment adjustment for covered professional services billed under each associated TIN/NPI combination in the 2020 payment year.

There may also be instances when a MIPS eligible clinician with a 2018 MIPS final score bills Medicare in the 2020 payment year under a TIN/NPI combination that he or she did not use during the 2018 performance period. In such cases, we will apply the payment adjustment associated with the highest 2018 final score associated with the NPI under any TIN during 2018.

Table 3: Which Payment Adjustment is Applied: New or Multiple TIN/NPI Combinations

Scenario	Payment Adjustment
Clinician has a 2018 final score under **TIN A.** Clinician continues to bill under **TIN A** in the 2020 payment year.	Clinician will receive a payment adjustment for covered professional services under their **TIN A**/NPI combination based on 2018 final score attributed to that **TIN A**/NPI combination.
Clinician has a single 2018 final score, received at **TIN A**. Clinician bills under **TIN B** in the 2020 payment year.	Clinician will receive a payment adjustment for covered professional services under their **TIN B**/NPI combination based on 2018 final score attributed to their **TIN A**/NPI combination.
Clinician has a 2018 final score under **TIN A**. Clinician has a 2018 final score under **TIN B**. Clinician bills under **TIN C** in the 2020 payment year.	Clinician will receive a payment adjustment for covered professional services under their **TIN C** /NPI combination based on their higher 2018 final score – either attributed to their **TIN A**/NPI combination or **TIN B**/NPI combination.
Clinician has a 2018 final score under **TIN A**. Clinician has a 2018 final score under **TIN B**. Clinician bills under **TIN A** and **TIN B** in the 2020 payment year.	Clinician will receive a payment adjustment for covered professional services under their **TIN A**/NPI combination based on 2018 final score attributed to that **TIN A**/NPI combination Clinician will receive a payment adjustment for covered professional services under their **TIN B** /NPI combination based on 2018 final score attributed to that **TIN B** /NPI combination

Please refer to the Frequently Asked Questions section for information about additional payment adjustment scenarios.

Application of MIPS Payment Adjustments in the 2020 Payment Year

2020 MIPS payment adjustments are applied only to payments made for covered professional services (services for which payment is made under, or based on, the Medicare Physician Fee Schedule (PFS)) furnished by a MIPS eligible clinician. The payment adjustment is applied to the Medicare paid amount (not the "allowed amount") and doesn't impact the portion of the payment that a beneficiary is responsible to pay. The PFS Look-Up Tool provides information on services covered by PFS, including fee schedule status indicators. Definitions of these procedure status indicator codes (or "PROC STAT" codes) are found on page 9 of the "PF19PA.pdf" in the PFS National Payment Amount File.

MIPS payment adjustments are applied only to claims that are billed and paid on an assignment-related basis[2] for covered professional services furnished by MIPS eligible clinicians. For MIPS eligible clinicians who are Medicare participating health care professionals, all claims are paid on an assignment-related basis. Non-participating health care professionals may choose to have claims paid on an assignment-related basis[3].

MIPS payment adjustments are **not** applied to:

- Non-assigned claims[4] for services furnished by non-participating clinicians,[5]
- Covered professional services furnished during a year by a new Medicare-enrolled eligible clinician, or
- Medicare Part B drugs or other items and services that are not covered professional services.

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[2] Accepting assignment of the Medicare Part B payment means having the beneficiary assign to the clinician their right to receive Medicare Part B payment for covered services. Under assignment, the Medicare-approved charge is the full charge for the Part B covered service. The participating clinician shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance. Assigned claims are submitted by the health care professional/supplier/provider on behalf of the beneficiary and Medicare issues payment to the submitter.

[3] Participating health care professionals have enrolled in Medicare and have signed the Form CMS-460, "Medicare Participating Physician or Supplier Agreement," agreeing to charge no more than Medicare-approved charge and deductibles and coinsurance amounts.

[4] Non-assigned claims are those submitted by a nonparticipating health care professional or supplier who is not accepting assignment on the claim. In such cases, Medicare issues payment to the beneficiary, and a limiting charge applies.

[5] Nonparticipating health care professionals and suppliers enroll in Medicare but have decided not to sign the Form CMS-460. They may choose whether to accept assignment on a claim-by-claim basis. For services furnished by nonparticipating health care professionals and suppliers that are paid under the Medicare PFS, there is a 5 percent reduction in the Medicare-approved amounts. There is also a limit on what the health care professional/ supplier may charge the beneficiary (referred to as a "limiting charge") when they choose not to accept assignment on the claim.

Suppliers, such as independent diagnostic testing facilities (IDTFs), are not included in the definition of a MIPS eligible clinician. In situations where a supplier bills for Part B covered professional services furnished by a MIPS eligible clinician, those services could be eligible to receive a MIPS payment adjustment based on the MIPS eligible clinician's performance during the applicable MIPS performance period. However, because those services are billed by suppliers that are not MIPS eligible clinicians, they are not subject to a MIPS payment adjustment. It is not operationally possible for CMS to associate those services (in the form of billed allowed charges from a supplier) as originating from a MIPS eligible clinician.

Frequently Asked Questions & Answers

The following questions & answers illustrate how final scores are assigned in different scenarios and how MIPS payment adjustments are applied.

Q: I'm a MIPS eligible clinician who billed under the TINs of three separate practices during the 2018 MIPS performance period. Each practice reported to MIPS as a group and received a separate 2018 MIPS final score and payment adjustment. How will this impact my payments in 2020?

A: You will receive a MIPS payment adjustment for each associated TIN/NPI combination in 2020. For every covered professional service that you furnish to patients in 2020 using one of the three scored TIN/NPI combinations, your Medicare Part B payment will be adjusted according to the final score and payment adjustment assigned to that TIN/NPI.

Q: I'm a MIPS eligible clinician who billed under multiple TINs during the 2018 MIPS performance period. Could I have multiple payment adjustments in 2020?

A: Yes. If you were MIPS eligible under multiple TIN/NPI combinations, you may receive a distinct MIPS payment adjustment for covered professional services furnished in 2020 and billed under each of those TIN/NPI combinations.

Q: We have a MIPS eligible clinician who started billing Medicare claims under our practice's existing TIN in October 2018. We participate as a group. Will this clinician receive a payment adjustment based on our group's final score?

A: Yes. We've updated this policy from the 2017 performance period.

- MIPS eligible clinicians who started billing to a group's existing TIN between 9/1/2018 and 12/31/2018 will receive the group's final score and payment adjustment in the 2020 payment year.
- If the practice had not participated as a group, the MIPS eligible clinician would receive a neutral payment adjustment under this TIN/NPI combination in the 2020 payment year.

Please refer to the 2018 MIPS Eligibility Redetermination Fact Sheet for more information about clinicians who started billing under a TIN during the performance year but after the second segment of the MIPS Determination Period.

Q: We established a new TIN in September 2018, but our old TIN was eligible for MIPS as a group. We submitted MIPS data as a group under the old TIN, where it was billed and collected. What payment adjustment will our clinicians get?

A: Clinicians who started billing claims under this new TIN between 9/1/2018 and 12/31/2018 will receive a neutral payment adjustment under this TIN in the 2020 payment year.

Clinicians who start billing under this new TIN after 12/31/2018 (i.e. after the performance period) will receive the highest payment adjustment attributed to their NPI when billing under this new TIN in the 2020 payment year.

Q: If a QP is part of a group that submitted MIPS data on behalf of all the individual eligible clinicians in its group, will the QP receive a 2020 payment adjustment based on that group's 2018 final score?

A: No, the group's 2020 MIPS payment adjustment does not apply to clinicians in that group who were also determined to be a QP in 2018. Instead, clinicians in the group who are QPs will receive the 5% APM Incentive Payment.

Q: I participate in an Advanced APM and I am not a Qualifying APM Participant (QP). How does the payment adjustment work for me?

A: If your APM Entity participates in an Advanced APM that is also designated as a MIPS APM and the APM entity group exceeded the low volume threshold, you were scored under the APM scoring standard and will receive a MIPS payment adjustment determined by the APM Entity's final score.

If your Advanced APM is not designated as a MIPS APM, your eligibility and MIPS payment adjustment will be determined according to standard MIPS policies (see Who Will Receive a MIPS Payment Adjustment in 2020?)

Q: How are payment adjustments determined for virtual groups?

A: Virtual groups will have their performance assessed and scored at the virtual group level across all 4 performance categories. While whole TINs participate in a virtual group, only NPIs who meet the definition of a MIPS eligible clinician as an individual or as part of a group are subject to a MIPS payment adjustment.

For MIPS eligible clinicians participating in both a virtual group and MIPS APM or Advanced APM, such MIPS eligible clinicians would earn a final score based on the virtual group's performance and a final score based on the APM scoring standard, but would receive a payment adjustment based on the final score under the APM scoring standard.

For more information, please refer to the 2018 Virtual Groups Toolkit.

Q: Is the 2020 MIPS payment adjustment applied before or after sequestration?

A: Before sequestration. Sequestration is the automatic reduction in Medicare fee-for-service (FFS) payments to plans and providers, resulting from the Budget Control Act of 2011. The MIPS payment adjustment percentage is applied to the Medicare paid amount for covered professional services furnished by a MIPS eligible clinician after calculating deductible and coinsurance amounts but before sequestration.

Q: Is the 2020 MIPS payment adjustment applied to the Medicare paid amount or Medicare allowed amount?

A: The MIPS payment adjustment is applied to the Medicare paid amount for covered professional services (services for which payment is made under, or is based on, the Medicare Physician Fee Schedule) furnished by a MIPS eligible clinician.

Q. How is the 2020 MIPS payment adjustment applied to services that are "globally billed," meaning services are split into separate professional component (PC) and technical component (TC) services when the PC and TC are furnished by the same physician or supplier entity?

A: The MIPS payment adjustment is applied to all paid charges for both the TC and PC of a globally billed service.

Q: Are payments for radiology services subject to 2020 MIPS payment adjustments?

A: The professional component of radiology services furnished by a physician to an individual patient in all settings under the Medicare Physician Fee Schedule are subject to the MIPS payment adjustment. Radiology and other diagnostic services furnished to hospital outpatients are paid under the Outpatient Prospective Payment System (OPPS) to the hospital and are not subject to MIPS payment adjustments.

Q. Are payments for federally qualified health center (FQHC) and rural health center (RHC) benefits subject to 2020 MIPS payment adjustments?

A: No. All professional services in the RHC and FQHC benefit are paid through the all-inclusive rate (AIR) system or the FQHC prospective payment system (PPS) for each patient encounter or visit. FQHC Healthcare Common Procedure Coding System (HCPCS) codes are not priced by the Medicare PFS.

Q: Are payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) subject to 2020 MIPS payment adjustments?

A: No, payments for DMEPOS are made according to a separate fee schedule (see: (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html). They are not considered covered professional services payable under the Medicare PFS.

Q: Do 2020 MIPS payment adjustments impact Medicare Advantage Organization (MAO) payments to non-contract providers? If so, how?

A: Pursuant to section 1852(a)(2) of the Act, the total of enrollee cost sharing and MAO payments to non-contracted health care providers for covered services provided to the MAO's enrollees must be equal to what the provider would be paid under Parts A and B for the covered services. Therefore, when a MIPS eligible clinician furnishes covered professional services to a Medicare Advantage (MA) plan member on a non-contract basis, the combined payment that the clinician receives from the MA plan and the plan member must be no less than the total MIPS-adjusted payment amount that the clinician would have received under Medicare FFS. Although MAOs are required to reflect positive MIPS payment adjustments in payments for covered professional services to non-contract MIPS eligible clinicians, application of any negative MIPS payment adjustment is at the discretion of the MAO.

Additional guidance is contained in the following resources:

- April 27, 2018 HPMS Memo entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments." The memo is available here [document title: 2019 MIPS HPMS Memo (04-27-2018).pdf]
- November 8, 2018 HPMS Memo entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – File Layout and Additional Guidance." The memo is available here [document title: 2019 MIPS HPMS Memo (11-08-2018) Final.pdf"]
- January 8, 2019 HPMS Memo entitled "Release of 2019 MIPS Payment Adjustment Data File." This memo is available here [document title: 2019_MIPS_Payment_Adju_Data_File_Release_Memo.pdf]

Q: Do 2020 MIPS payment adjustments impact Medicare Advantage payments to in-network/contracted providers? If so, how?

A: Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in payment arrangements between MAOs and contract clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO's payments to its contract clinicians are governed by the terms of the contract between the MAO and the clinician.

Additional guidance is contained in April 27, 2018 HPMS Memo entitled "Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments." The memo is available here [document title: 2019 MIPS HPMS Memo (04-27-2018).pdf]

Q: Are MIPS payment adjustments applied to items and services furnished by MIPS eligible clinicians in an Ambulatory Surgical Center (ACS), Home Health Agency (HHA), Hospice, and/or hospital outpatient department (HOPD)?

A: If a MIPS eligible clinician furnishes items and services in an ASC, HHA, Hospice, and/or HOPD and the ASC, HHA, Hospice and/or HOPD bills for those items and services under the facility's all-inclusive payment methodology or prospective payment system methodology, then the MIPS payment adjustment is not applied to the facility payment itself.

If a MIPS eligible clinician furnishes covered professional services for which payment is made under or is based on the Medicare PFS in an ASC, HHA, Hospice and/or HOPD and bills for those services separately, then the MIPS payment adjustment is applied to payments for those services.

Q: How are payment adjustments applied to MIPS eligible clinicians practicing in Critical Access Hospitals (CAHs)?

A: For MIPS eligible clinicians who practice in Method II CAHs and have assigned their billing rights to the Method II CAH, the MIPS payment adjustment is applied to the Method II CAH payment.

For MIPS eligible clinicians who practice in Method II CAHs and have not assigned their billing rights to the CAH, the MIPS payment adjustment is applied to payments for covered professional services billed by the MIPS eligible clinicians under the Physician Fee Schedule (PFS). The payment adjustment is not applied to the facility payment to the Method II CAH itself.

For MIPS eligible clinicians who practice in CAHs that bill under Method I, the MIPS payment adjustment is applied to payments for covered professional services billed by MIPS eligible clinicians under the PFS. The MIPS payment adjustment would not apply to the facility payment made to the Method I CAH itself.

Q: How will 2020 MIPS payment adjustments be reflected on remittance advice (RA) documents?

A: If a 2020 MIPS payment adjustment is applied to a payment made to a MIPS eligible clinician, the following codes will be displayed on the RA[6]:

Positive MIPS Payment Adjustments	***CARC[7] 144*:** "Incentive adjustment, e.g. preferred product/service"	***RARC[8] N807*:** "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	**Group Code[9]: CO**. This group code is used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment.
Negative MIPS Payment Adjustments	***CARC 237***: "Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"	***RARC N807*:** "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	**Group Code: CO**

For all list of *all* CARCs and RARCs please see the following resources:

- Claim Adjustment Reasons Codes (CARCs)
- Remittance Advice Remark Codes (RARCs)

[6] When you submit a claim to a Medicare Administrative Contractor, you will receive a Remittance Advice that explains the payment and any adjustment(s) made to a payment during Medicare's adjudication of the claim. RAs provide itemized claims processing decision information regarding deductibles and co-pays, adjustments, denials, missing or incorrect data, claims withholding due to Medicare Secondary Payer situations, and more. For additional detailed information, please reference the Medicare Learning Network's (MLN) Remittance Advice Overview Fact Sheet.

[7] Claim Adjustment Reason Codes (CARCs) provide financial information about claim decisions. CARCs communicate adjustments the MAC made and provide explanations when the MAC pays a claim or service line differently than what was on the original claim.

[8] Remittance Advice Remark Codes (RARCs) further explain an adjustment or relay informational messages that CARCs cannot express.

[9] A group code is a code identifying the general category of payment adjustment. A group code is always used in conjunction with a CARC to show liability for amounts not covered by Medicare for a claim or service. For more information on group codes, visit the Medicare Claims Processing Manual, Chapter 22 (Remittance Advice), Section 60.1 (Group Codes).

Q: Will beneficiaries be notified if a claims payment made to one of their clinicians was adjusted due to that clinician's participation in MIPS?

A: Yes. Every three months, Original Medicare beneficiaries receive a Medicare Summary Notice (MSN) in the mail for their Medicare Part A and Part B-covered services. MSNs show a beneficiary all of his/her services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and the maximum amount the beneficiary may owe the provider or supplier. For all the beneficiary's claims for which the clinician who furnished the service received a positive or negative MIPS payment adjustment, the following MSN message will be displayed: "This claim shows a quality reporting program adjustment."

How Do I Get Help or More Information?

You can reach the Quality Payment Program at 1-866-288-8292 (TTY 1-877-715-6222), Monday through Friday, 8:00 AM-8:00 PM ET or by e-mail at: QPP@cms.hhs.gov.