

Fact Sheet: 2019 Merit-based Incentive Payment System (MIPS) Payment Adjustments based on 2017 MIPS Final Scores

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate formula, strengthens Medicare access by improving payments to physicians and other clinicians, and rewards value and outcomes by establishing the Quality Payment Program. Under the Quality Payment Program, eligible clinicians can participate in one of two tracks:

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (Advanced APMs)

In July 2018, each MIPS eligible clinician will receive a 2017 MIPS final score, and payment adjustment, for the first year of the program as part of their performance feedback report. This final score determines a clinician's 2019 MIPS payment adjustment; affecting payments for services in calendar year (CY) 2019, also referred to as the 2019 MIPS payment year.

This fact sheet will:

- Review important program definitions and 2017 MIPS eligibility & exclusion criteria
- Discuss how CMS assigns final scores to MIPS eligible clinicians
- Explain how payment adjustment factors are applied, resulting in actual adjustments to payments for covered professional services furnished by MIPS eligible clinicians in CY 2019
- Define the 2017 MIPS performance period thresholds and describe the relationship between these thresholds and the different types of payment adjustments a clinician can receive
- Describe how final scores for a performance period are converted into MIPS payment adjustment factors for a MIPS payment year
- Address other important topics related to MIPS payment adjustments, such as what happens when a clinician bills under a new Taxpayer Identification Number (TIN), the impact of budget neutrality, and application of scaling factors to certain types of payment adjustments



Program Definitions: MIPS Eligibility & Exclusion Criteria

Eligible Clinician vs. MIPS Eligible Clinician

The definition of an “eligible clinician” comes from the Social Security Act (SSA). An eligible clinician means “eligible professional” as defined in section 1848(k)(3) of the SSA, and includes any of the following: a physician, a practitioner described in section 1842(b)(18)(C) of the SSA, a physical or occupational therapist or qualified speech- language pathologist, and/or a qualified audiologist. Eligible clinicians are identified by unique TIN and National Provider Identifier (NPI) combinations.

Not all eligible clinicians are MIPS eligible clinicians. Eligible clinicians who aren’t deemed MIPS eligible clinicians in a given performance year will not receive a MIPS payment adjustment in the associated payment year. Eligible clinicians who are not MIPS eligible clinicians have the option to voluntarily report measures and activities for MIPS. Eligible clinicians who voluntarily report on measures and activities but are not MIPS eligible clinicians won’t receive a payment adjustment.

A MIPS eligible clinician means any of the following Medicare-participating clinician types, identified by a unique billing TIN and NPI to assess performance:

- Physician¹
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Group that includes such clinicians

Exclusions

The following are not considered MIPS eligible clinicians and will not receive a MIPS payment adjustment:

- Qualifying APM Participants (QPs), who are clinicians participating sufficiently in Advanced APMs
- Partial Qualifying APM Participants (Partial QPs), who don’t report on applicable measures and activities required under MIPS for a year. For more information on how CMS determines which eligible clinicians are QPs or Partial QPs for a year, please refer to this [methodology factsheet](#).
- Eligible clinicians or groups who didn’t exceed the low-volume threshold. To exceed the low-volume threshold, individual eligible clinicians or groups must have had greater than \$30,000 in Medicare Part B allowed charges *and* must have provided care for more than 100 Part B-enrolled Medicare beneficiaries, based on claims data.

¹ The definition includes: Doctor of Medicine or osteopathy, Doctor of Dental Medicine, Doctor of Dental Surgery, Doctor of Podiatric Medicine, Doctor of Optometry, and chiropractor.


- The low-volume status of individual eligible clinicians and groups for the 2019 MIPS payment adjustment was determined based on analysis of two 12-month segments of claims data, referred to as determination periods. The first determination period was based on claims from 9/1/2015-8/31/2016, the second determination period was based on claims from 9/1/2016-8/31/2017.
- An individual eligible clinician or group that was identified as not exceeding the low-volume threshold during the first eligibility determination analysis continued to be excluded from MIPS for the duration of the performance period regardless of the results of the second eligibility determination analysis.
- New Medicare-enrolled eligible clinicians (eligible clinicians who first become a Medicare-enrolled eligible clinician within the Provider, Enrollment, Chain and Ownership System (PECOS) during 2017 and had not previously submitted claims under Medicare as an individual, an entity, or as part of a physician group or under a different billing number or tax identifier).

MIPS Participation, Performance Evaluation & Payment Adjustment Application: Individuals vs. Groups

MIPS eligible clinicians choose to have their performance evaluated individually or as part of a group. Individual MIPS eligible clinicians are identified by a unique TIN and NPI combination. A group is defined as a single TIN with two or more eligible clinicians (including at least one MIPS eligible clinician) who have reassigned their billing rights to the TIN. Eligible clinicians and MIPS eligible clinicians within a group must aggregate their performance data across the TIN for their performance to be assessed as a group. A group that elects to have its performance assessed as a group will be assessed as a group across all four MIPS performance categories. MIPS eligible clinicians participating in MIPS APMs have their performance evaluated according to the MIPS APM scoring standard. Under the MIPS APM scoring standard, the quality measures required by the Medicare Shared Savings Program and the Next Generation ACO Model are used to determine a MIPS Quality performance category score and the Quality performance category is weighted at 50% for the 2017 performance year. For all other MIPS APMs, the Quality performance category weight is zero for the 2017 performance year. This [fact sheet](#) provides more information about the MIPS APM Scoring Standard. The following questions & answers illustrate how payment adjustments are applied based on different ways of participating in the program.

Question: Dr. Alice Jones did not exceed the low-volume threshold for 2017 as an individual. She assigned her billing rights to Atlantic Practice Group's TIN in 2017. Atlantic Practice Group (identified by a TIN) exceeded the low-volume threshold in 2017 and chose to report MIPS data for all individual clinicians billing under its TIN and to have its performance scored & assessed as a group. Atlantic Practice Group received a 2017 MIPS final score of 75 points and will receive a positive payment adjustment. Will Atlantic Practice Group's score and payment adjustment be applied to Dr. Jones in 2019?

Answer: Yes, the group's final score and 2019 payment adjustment will be applied to Dr. Jones. The low-volume threshold exclusion is determined at the individual (TIN/NPI) level for



individual reporting, at the group (TIN) level for group reporting. For clinicians participating in an APM, the low volume threshold is determined at the APM entity level.

In this case, the eligible clinician didn't exceed the low-volume threshold and would have been excluded from MIPS as an individual, but since the eligible clinician was part of a group that exceeded the low-volume threshold and chose to report as a group, that individual eligible clinician is required to participate in MIPS as part of the group.

Question: Mary Jefferson is an occupational therapist who reassigned her Medicare billing rights to Mercy Physician Group's TIN. Mercy Physician Group exceeded the low-volume threshold for 2017 and reported to MIPS as a group by aggregating and submitting MIPS performance data for all the individual eligible clinicians who reassigned their billings right to their TIN. Will Mary Jefferson's payments be adjusted in 2019 based on Mercy Physician Group's final score?

Answer: No, Mary Jefferson will not receive a 2019 MIPS payment adjustment. Occupational therapists are not considered MIPS eligible clinicians in the 2017 MIPS performance period. Mercy Physician Group voluntarily submitted Mary Jefferson's data. Groups that voluntarily include eligible clinicians who do not meet the definition of a MIPS eligible clinician are assessed and scored as a group, but clinicians in the group who don't meet the definition of a MIPS eligible clinician will not receive a MIPS payment adjustment.

Question: 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 2019 payment adjustment based on that group's 2017 final score?

Answer: No, the group's 2019 MIPS payment adjustment would not be applied to clinicians in that group who were also determined a QP in 2017. Instead, QPs will be eligible to receive the 5% APM Incentive Payment

Assigning Final Scores to MIPS Eligible Clinicians

A MIPS eligible clinician's data could have been submitted to CMS for evaluation as:

- a) an individual
- b) a group; and/or
- c) an APM Entity

For groups who submitted data using their TIN identifier, the group's final score will be applied to all MIPS eligible clinicians (TIN/NPI combinations) that billed under that TIN during the performance period.

An APM Entity's final score is assigned to all MIPS eligible clinicians participating in an APM Entity during the performance period.

It's possible for more than one MIPS final score to be associated with a single TIN/NPI. If an individual MIPS eligible clinician is a participant in a MIPS APM under a TIN/NPI and the group





(TIN) reports to MIPS independently from the APM, then two scores (group and APM Entity score) would be associated with the same TIN/NPI.

However, only one MIPS final score is assigned to each unique TIN/NPI combination to calculate and apply a MIPS payment adjustment for that specific TIN/NPI.

The following questions & answers illustrate how payments are adjusted in different scenarios.

What happens if more than one final score is associated with a single TIN/NPI combination?

If multiple final scores are associated with one of a MIPS eligible clinician's TIN/NPI combinations, the following hierarchy is used to assign one final score to that TIN/NPI:

- If a MIPS eligible clinician is a participant in a MIPS APM, then the APM Entity final score is used instead of any other final score.
- If a MIPS eligible clinician received more than one APM Entity final score, then the highest APM Entity score will be used.
- If a MIPS eligible clinician reported both as an individual and through a group and is not part of an APM Entity, the higher of the two final scores will be used.


I'm a MIPS eligible clinician who billed under the TINs of three separate practices during the 2017 MIPS performance period. Each practice reported to MIPS as a group and received a separate 2017 MIPS final score and payment adjustment. How will this impact my payments in 2019?


You will receive a MIPS payment adjustment for each associated TIN/NPI combination in 2019. For every covered professional service for which payment is made under or is based on the Medicare Physician Fee Schedule (PFS) you furnish to patients in 2019 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.

Dr. Emily Delta is a MIPS eligible clinician who received one 2017 MIPS final score assigned to the TIN of the practice she previously billed under. Dr. Delta left that practice and now bills for services using a different practice's TIN in 2019. What happens if a clinician bills for services under a new or different TIN in 2019?

Dr. Delta does not have a 2017 MIPS final score associated with her new TIN/NPI combination she is using to bill Medicare in 2019. In cases where there is no 2017 MIPS final score associated with a TIN/NPI that's being used in 2019--because a clinician changed practices or established a new TIN--CMS will apply the payment adjustment associated with the NPI's final score under the TIN(s) the NPI was billing under during the 2017 performance period.

Since only one 2017 MIPS final score is associated with her NPI, that score will be assigned to her and payments made to her new 2019 TIN/NPI combination for covered professional services she furnishes will be adjusted based on that score.





If Dr. Delta billed under multiple TINs during 2017 and had several MIPS final scores associated with her NPI (one score for each of the TINs/practices), then the highest score would be assigned to her for MIPS payment year 2019.

Dr. Andrew Scott worked at Providence Practice Group from November 1, 2017, through December 31, 2017. Providence Practice Group reported to MIPS as a group for the 2017 MIPS performance period, received a final score of 15, and will get a positive payment adjustment. Will Dr. Scott receive a 2019 payment adjustment based on the final score assigned to Providence Practice Group's TIN?

No. Individual MIPS eligible clinicians who started billing to a group's TIN between 9/1/2017 and 12/31/2017 will receive a neutral payment adjustment for that TIN in the 2019 payment year.

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

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.


Application of Payment Adjustments

Payment adjustments will only apply to payments made for covered professional services for which payment is made under, or is based on, the Medicare Physician Fee Schedule and are furnished by a MIPS eligible clinician. The payment adjustment will not apply to Medicare Part B drugs or other items and services that are not covered professional services. The payment adjustment is applied to the Medicare paid amount, so it does not impact the portion of the payment that a beneficiary is responsible to pay.

Payments for these services furnished in 2019 by a MIPS eligible clinician are adjusted based on the clinician's 2017 MIPS final score. Payment adjustments do not apply to covered professional services furnished during a year by a new Medicare-enrolled eligible clinician.

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.

Are MIPS payment adjustments applied to payments for services furnished by non-Medicare enrolled providers and suppliers?

No. 2019 MIPS payment adjustments are applied only to payments for covered professional services for which payment is made under or is based on the Medicare PFS and are furnished by a MIPS eligible clinician who received a 2017 MIPS final score & payment adjustment based on their participation in MIPS as either an individual or as part of a group or an APM entity.

Clinicians who are not enrolled in Medicare are not required to participate in MIPS and are not subject to MIPS payment adjustments.

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


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 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]

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

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]





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

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.

Performance Thresholds

A performance threshold is the number against which final scores of MIPS eligible clinicians are compared to determine whether a MIPS eligible clinician will receive a positive, negative or neutral adjustment to payments for the covered professional services they furnish in the MIPS payment year.

There are two thresholds: 1) the performance threshold and 2) the additional performance threshold for exceptional performance.

Setting a performance threshold ensures a minimum number of points are earned before a MIPS eligible clinician receives a positive payment adjustment. The performance threshold for the 2019 MIPS payment year is 3 points—this means a 2017 MIPS final score of at least 3 is required to avoid a negative payment adjustment in CY 2019. A threshold of 3 points allows MIPS eligible clinicians who successfully reported one quality measure to avoid a negative payment adjustment.

The additional performance threshold for exceptional performance for the 2019 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 (referred to later in this fact sheet as the “exceptional performance bonus”).

MIPS Payment Adjustment Factors

MIPS payment adjustment factors are expressed as a percentage and tell a clinician the amount by which his/her payments will be adjusted in a future MIPS payment year.

Each MIPS eligible clinician receives a MIPS payment adjustment factor (and an accompanying payment adjustment) based on their MIPS final score. Payment adjustment factors are assigned on a linear sliding scale and are based on an applicable percent defined by law. For the 2019 MIPS payment year, the linear sliding scale ranges from 0 to 4 percent for scores from 3 to 100 points. As a result, the higher a MIPS eligible clinician's final score, the larger the positive payment adjustment, explained below.




ILLUSTRATION OF POINT SYSTEM AND ASSOCIATED PAYMENT ADJUSTMENTS					
FINAL SCORE POINTS	0 - 0.75	0.76-2.9	3.0	3.1-69.9	70.0-100
MIPS ADJUSTMENT	Negative 4 percent (Note: We anticipate that this range will comprise mostly of MIPS eligible clinicians with a final score of 0)	Negative MIPS payment adjustment greater than negative 4 percent and less than 0 percent on a linear sliding scale (Note: We do not anticipate many MIPS eligible clinicians will fall into this range)	0 percent adjustment	Positive MIPS payment adjustment ranging from greater than 0 percent to 4 percent x a scaling factor to preserve budget neutrality, on a linear sliding scale	Positive MIPS payment adjustment and additional MIPS payment adjustment for exceptional performance (Additional MIPS payment adjustment starting at 0.5 percent and increasing on a linear sliding scale to 10 percent multiplied by a scaling factor)

Budget Neutrality & Scaling Factors

MIPS payment adjustments are required by law to be budget neutral, meaning the estimated increase in aggregate allowed charges resulting from the application of positive MIPS payment adjustment factors must equal the estimated decrease in aggregate allowed charges resulting from the application of negative MIPS payment adjustment factors for the MIPS payment year.


Because of this requirement, positive MIPS payment adjustment factors may be increased or decreased (or “scaled”) by an amount called a “scaling factor.” The amount of the scaling factor, or the amount by which a positive MIPS payment adjustment factor is increased or decreased, depends on the distribution of final scores across all MIPS eligible clinicians. For the 2019 MIPS payment year, a scaling factor not to exceed 3 may be applied to positive MIPS payment adjustment factors to ensure budget neutrality.

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 (4 percent) for 2019. 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 4 percent for 2019.

Payment Adjustments for Exceptional Performance

MIPS eligible clinicians with final scores of 70 or above will be rewarded with an additional payment adjustment factor on a linear sliding scale, similar to the way standard MIPS payment adjustment factors are applied. The performance feedback displays the MIPS payment adjustment factor and the additional payment adjustment factor for exceptional performance; each figure is displayed separately. The system will continue to display your total MIPS payment adjustment, which is a sum of both payment adjustment factors.

Although the additional payment adjustment factors for exceptional performance aren’t required to be budget neutral, the estimated aggregate increase in payments resulting from the additional payment adjustment factors for exceptional performance for all MIPS eligible clinicians cannot



exceed \$500 million in 2019. As a result, additional payment adjustment factors for exceptional performance may also be “scaled” by a scaling factor that is less than one in order to proportionately distribute the available funds for exceptional performance.

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.

