

2022 Merit-based Incentive Payment System (MIPS) Payment Year Payment Adjustment User Guide

Introduction

In August 2021, each MIPS eligible clinician will receive a 2020 MIPS Final Score and 2022 MIPS payment adjustment information as part of their performance feedback. The 2022 MIPS payment adjustment, determined by the 2020 Final Score, will affect payments made for services in calendar year 2022, also referred to as the 2022 MIPS payment year.

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ACRONYMS

NPI = National Provider Identifier (unique identifier assigned to clinicians when they enroll as Medicare providers)

TIN = Taxpayer Identification Number, sometimes referred to as an Employer Identification Number (unique identifier assigned by IRS or SSA)

Type of Payment Adjustment	Impact to Payments in 2022
Positive	Each covered professional service you furnish in 2022 is reimbursed more than 100% – increase to paid amount
Neutral	Each covered professional service you furnish in 2022 is reimbursed 100% – no increase or decrease to paid amount
Negative	Each covered professional service you furnish in 2022 is reimbursed less than 100% – decrease to paid amount



Who Will Receive a MIPS Payment Adjustment in 2022?

MIPS eligible clinicians, identified by TIN/NPI combination for the 2020 performance year, will receive a MIPS payment adjustment in 2022. Specifically, you'll receive a MIPS payment adjustment in 2022 if, for the 2020 performance year, you:

- Were a clinician type that was included in MIPS; AND
- Enrolled as a Medicare provider prior to January 1, 2020; AND
- **Weren't** identified as a Qualifying Alternative Payment Model (APM) Participant (QP¹); AND
- Were a Partial Qualifying APM Participant (Partial QP) that elected 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 opt-in eligible and elected to opt-in to MIPS as an individual or group; OR
 - Were part of an approved virtual group; OR
 - Were in a MIPS APM and the APM Entity group exceeds the low-volume threshold or opted in to MIPS (see footnote below; also includes Partial QPs who elected to participate in MIPS).

A single clinician, identified by NPI, that billed Medicare under multiple TINs during 2020, can receive a separate 2020 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 furnished and billed under each of their TIN/NPI combinations in the 2022 payment year.

¹ A QP is an eligible clinician participant in an Advanced APM who CMS has determined either met or exceeded the relevant QP payment amount or QP patient count threshold. If you participate in an Advanced APM that's also designated as a MIPS APM **and** you're not a QP, then you'll be scored under the APM scoring standard if the APM Entity group exceeds the low-volume threshold.

Determining Your 2022 MIPS Payment Adjustment


If you meet the criteria above, the Final Score associated with your TIN/NPI combination determined your payment adjustment. Your Final Score was compared to performance thresholds to determine whether you'll receive a positive, negative, or neutral adjustment to payments for the covered professional services you furnish in the 2022 MIPS payment year.

1. **The performance threshold for the 2022 MIPS payment year is 45 points.** This means that MIPS eligible clinicians with a 2020 MIPS Final Score of 45 points or higher will avoid a negative payment adjustment in the 2022 MIPS payment year.
2. **The additional performance threshold for exceptional performance for the 2022 MIPS payment year is 85 points.** A MIPS eligible clinician with a Final Score of 85 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 2020 MIPS Final Scores Relate to 2022 MIPS Payment Adjustments

Final Score Points	MIPS Payment Adjustment
0.00 – 11.25 points	Negative (-) MIPS payment adjustment of -9%
11.26 – 44.99 points	Negative (-) MIPS payment adjustment, between 0% and -9%, on a linear sliding scale
45.00 points (Performance threshold=45.00 points)	Neutral MIPS payment adjustment (0%)
45.01 – 84.99 points	<ul style="list-style-type: none"> • Positive (+) MIPS payment adjustment, greater than 0%, on a linear sliding scale and multiplied by a scaling factor to preserve budget neutrality • Not eligible for an additional adjustment for exceptional performance
85.00 – 100.00 points (Additional performance threshold=85.00 points)	<ul style="list-style-type: none"> • Positive (+) MIPS payment adjustment, greater than 0%, on a linear sliding scale and multiplied by a scaling factor to preserve budget neutrality • AND • Additional positive (+) adjustment for exceptional performance on a linear sliding scale and multiplied by a scaling factor to proportionately distribute funds



Note: The Centers for Medicare & Medicaid Services (CMS) only displays payment adjustments to 2 decimal places in performance feedback.

How Do COVID-19 Relief Efforts Affect 2022 MIPS Payment Adjustments?

CMS extended the automatic extreme and uncontrollable circumstances (EUC) policy to all individual MIPS eligible clinicians for the 2020 performance year and re-opened the EUC application for individuals, groups, virtual groups and APM Entities, extending the deadline to March 31, 2021. These relief efforts were designed to allow the healthcare delivery system to focus on the 2019 Novel Coronavirus (COVID-19) response.

As a result, many MIPS eligible clinicians, who may have otherwise received a Final Score below the performance threshold and a negative payment adjustment, received a MIPS Final Score equal to the performance threshold and a neutral payment adjustment in the 2022 payment year.


The following flexibilities, implemented as part of our COVID-19 relief efforts, will affect 2022 MIPS payment adjustments:

General Flexibilities

- We doubled the complex patient bonus: You can earn up to 10 bonus points for the Complex Patient Bonus for the 2020 performance year (to be added to your 2020 MIPS Final Score).
- We reweighted the cost performance category from 15% to 0% for the 2020 performance period. The 15% cost performance category weight was redistributed to other performance categories. This reweighting of the cost performance category applies in addition to the EUC policies. See [Appendix C](#) for reweighting scenarios related to this flexibility.
- Clinicians who aren't covered by the automatic EUC policy or who didn't apply to request reweighting under the EUC policy will still have their cost performance category weighted to 0%.

Automatic EUC Policy Applied to MIPS Eligible Clinicians Participating as Individuals

- MIPS eligible clinicians participating as individuals were only scored on performance categories for which data was submitted. All other performance categories were reweighted to 0% of their Final Score.
- All individual MIPS eligible clinicians who didn't submit PY 2020 data automatically receive a neutral payment adjustment in 2022. The automatic policy wasn't applied to groups, virtual groups, or APM Entities.
- MIPS eligible clinicians participating as individuals who submitted 2020 MIPS data for one performance category by the March 31, 2021, deadline automatically received a



neutral payment adjustment. In other words, a MIPS eligible clinician participating as an individual who had multiple performance categories reweighted to 0% so that a single performance category was weighted as 100% of their Final Score, received a score equal to the performance threshold (regardless of whether any data was submitted).

- MIPS eligible clinicians participating as individuals who submitted 2020 MIPS data for 2 or 3 performance categories by the March 31, 2021, deadline received a Final Score based on the performance categories for which data was submitted and may earn a negative, neutral, or positive payment adjustment.

EUC Applications Submitted by Groups and Virtual Groups

- Groups and virtual groups (or a third party) were able to complete an application for one or more performance categories, citing they've been impacted by the COVID-19 pandemic.
- Groups and virtual groups weren't able to submit an EUC application to void previously submitted data. (This is different than our policy for Performance Year 2019.)

EUC Applications by APM Entities

- APM Entities were able to complete an application to request reweighting of all performance categories. Approved applications resulted in reweighting the affected performance categories to 0%.
- For APM Entities, approved applications did override previously submitted data.

For more information, please see [Appendix B](#) of this document (from the [COVID 19 Response Fact Sheet](#)), outlining performance category weights and payment adjustment implications based on data submission by individual clinicians. Also see [Appendix C](#) of this document for reweighting and payment adjustment implications for groups and virtual groups with an approved EUC application.

Budget Neutrality and Scaling Factors

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires MIPS to be a budget neutral program, which 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's 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 9% for 2022 (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 9% for 2022 (excluding the additional adjustment for exceptional performance).

A scaling factor is also applied to the additional adjustments for exceptional performance (i.e., Final Scores at or above 85 points). In this circumstance, the scaling factor is necessary to proportionally distribute the available funds to the clinicians who qualified.

The magnitude of the payment adjustment amount is influenced by 2 factors: the performance threshold and the distribution of Final Scores in comparison to the performance threshold in a given year. (The low-volume threshold, which is used to determine eligibility for the program, doesn't impact the magnitude of the payment adjustment.)

The modest positive payment adjustment you see for the 2022 payment year is a result of the following factors:

- A very small number of clinicians receiving a negative payment adjustment due to the flexibilities we introduced in response to COVID-19.
- High participation rates.
- A large percentage of Final Scores that were well above the relatively low performance threshold of 45 points.

With so many clinicians successfully participating, the distribution of positive adjustments is spread across many more people. This year's payment adjustment distribution was further affected because clinicians who didn't submit any data will receive a neutral payment adjustment instead of the maximum negative adjustment.

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'll use the hierarchy described in the table below to assign the Final Score that will be used to determine your payment adjustment applicable to that TIN/NPI combination.

Table 2: Hierarchy for Assigning the 2020 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 2 Final Scores (either group or individual).

Multiple TIN/NPI Combinations/Establishing a New TIN/NPI Combination After the 2020 Performance Year

There may be instances when a MIPS eligible clinician, identified by NPI, billed Medicare under multiple TINs during 2020. In this situation, the clinician can receive a separate 2020 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 2022 payment year.

There may also be instances when a MIPS eligible clinician with a 2020 MIPS Final Score bills Medicare in the 2022 payment year under a TIN/NPI combination that he/she didn't use during the 2020 performance year. In such cases, we'll apply the payment adjustment associated with the highest 2020 Final Score associated with the NPI under any TIN during 2020.

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

Scenario	Payment Adjustment
<p>Clinician has a 2020 Final Score under TIN A.</p> <p>Clinician continues to bill under TIN A in the 2022 payment year.</p>	<p>Clinician will receive a payment adjustment for covered professional services billed in 2022 under their TIN A/NPI combination based on 2020 Final Score attributed to that TIN A/NPI combination.</p>
<p>Clinician has a single 2020 Final Score, received at TIN A.</p> <p>Clinician bills under TIN B in the 2022 payment year.</p>	<p>Clinician will receive a payment adjustment for covered professional services billed in 2022 under their TIN B/NPI combination based on 2020 Final Score attributed to their TIN A/NPI combination.</p>
<p>Clinician has a 2020 Final Score under TIN A.</p> <p>Clinician has a 2020 Final Score under TIN B.</p> <p>Clinician bills under TIN C in the 2022 payment year.</p>	<p>Clinician will receive a payment adjustment for covered professional services billed in 2022 under their TIN C/NPI combination based on their higher 2020 Final Score – either attributed to their TIN A/NPI combination or TIN B/NPI combination.</p>
<p>Clinician has a 2020 Final Score under TIN A.</p> <p>Clinician has a 2020 Final Score under TIN B.</p> <p>Clinician bills under TIN A and TIN B in the 2022 payment year.</p>	<p>Clinician will receive a payment adjustment for covered professional services billed in 2022 under their TIN A/NPI combination based on 2020 Final Score attributed to that TIN A/NPI combination</p> <p>Clinician will receive a payment adjustment for covered professional services under their TIN B/NPI combination based on 2020 Final Score attributed to that TIN B/NPI combination.</p>

Please refer to the [Frequently Asked Questions](#) section for information about additional payment adjustment scenarios.

Application of MIPS Payment Adjustments in the 2022 Payment Year

MIPS payment adjustments are applied on a claim-by-claim basis, to payments made for covered professional services furnished by a MIPS eligible clinician.

- The payment adjustment is applied to the Medicare paid amount (not the “allowed amount”).
- Payment adjustments don’t impact the portion of the payment that a patient is responsible to pay.

A covered professional service is one which payment is made under, or based on, the Medicare Physician Fee Schedule (PFS). The [PFS Look-Up Tool](#) provides information on services covered by the PFS, including fee schedule status indicators. Definitions of these procedure status indicator codes (or “PROC STAT” codes) are found on pages 9-10 of the “PFREV21A.pdf” document, part of the [PFS National Payment Amount File](#).

MIPS payment adjustments are applied only to claims that are billed and paid on an assignment-related basis² for covered professional services furnished by MIPS eligible clinicians. For MIPS eligible clinicians who are Medicare-participating healthcare professionals, all claims are paid on an assignment-related basis. Non-participating healthcare professionals may choose to have claims paid on an assignment-related basis.³

² Accepting assignment of the Medicare Part B payment means having the patient 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 patient or other person or organization for covered services more than the applicable deductible and coinsurance. Assigned claims are submitted by the healthcare professional/supplier/provider on behalf of the patient and Medicare issues payment to the submitter.

³ Participating healthcare professionals have enrolled in Medicare and have signed the Form CMS-460, “Medicare Participating Physician or Supplier Agreement,” agreeing to charge no more than the Medicare-approved charge and deductibles and coinsurance amounts.

MIPS payment adjustments **aren't** applied to:

- Non-assigned claims⁴ for services furnished by non-participating clinicians.⁵
- Covered professional services furnished during a year by a new Medicare-enrolled eligible clinician.
- Medicare Part B drugs or other items and services that aren't covered professional services.

Suppliers, such as independent diagnostic testing facilities (IDTFs), aren't 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 year. However, because those services are billed by suppliers that aren't MIPS eligible clinicians, they aren't subject to a MIPS payment adjustment. It isn't 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.

⁴ Non-assigned claims are those submitted by a non-participating healthcare professional or supplier who isn't accepting assignment on the claim. In such cases, Medicare issues payment to the patient, and a limiting charge applies.

⁵ Non-participating healthcare 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 non-participating healthcare professionals and suppliers that are paid under the Medicare PFS, there's a 5% reduction in the Medicare-approved amounts. There's also a limit on what the healthcare professional/supplier may charge the patient (referred to as a "limiting charge") when they choose not to accept assignment on the claim.

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 multiple TINs during the 2020 MIPS performance year. Could I have multiple payment adjustments in 2022?

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 2022 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 2020. We participated as a group. Will this clinician receive a payment adjustment based on our group's Final Score?

A: Yes. MIPS eligible clinicians who started billing to a group's existing TIN between 10/1/2020 and 12/31/2020 will receive the group's Final Score and payment adjustment in the 2022 payment year.

However, 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 2022 payment year.

Q: We established a new TIN in October 2020, 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: MIPS eligible clinicians who started billing claims under this new TIN between 10/1/2020 and 12/31/2020 will receive a neutral payment adjustment under this TIN in the 2022 payment year.

MIPS eligible clinicians who start billing under this new TIN after 12/31/2020 (i.e., after the performance year) will receive the highest payment adjustment attributed to their NPI when billing under this new TIN in the 2022 payment year.

Q: If a Qualifying APM Participant (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 2022 payment adjustment based on that group's 2020 Final Score?

A: No, the group's 2022 MIPS payment adjustment doesn't apply to clinicians in that group who were also determined to be a QP in 2020. Instead, clinicians in the group who are QPs are eligible to 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's 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 isn't 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 2022?](#)).

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, 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 2020 Virtual Groups Toolkit.


Q: Is the 2022 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 2022 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 2022 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 2022 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 aren't subject to MIPS payment adjustments.

Q: Are payments for anesthesiology services subject to 2022 MIPS payment adjustments?

A: Per [Chapter 12 of the Medicare Claims Processing Manual \(see pg. 92\)](#) , the fee schedule amount for physician anesthesia services furnished is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the A/B Medicare Administrative Contractors (MACs) by means of the Healthcare Common Procedure Coding System (HCPCS) file released annually. CMS releases the conversion factor annually. The base units and conversion factor are available on the [CMS website](#).

Accordingly, in general, payments for anesthesiology services aren't subject to the MIPS payment adjustment because they aren't classified as Part B covered professional services for which payment is made under, or is based on, the Medicare PFS. A different fee schedule is used to determine payment for anesthesiology services. The base units and conversion factors used to construct the fee schedule for anesthesiology services are published annually in the final rule that contains annual PFS updates.

Please note: Application of the MIPS payment adjustment to payments for services rendered is separate from determining MIPS eligibility. Anesthesiologists aren't excluded from participation in MIPS. As a reminder, the MIPS eligible clinician types are: Physicians (includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry; osteopathic practitioners; and chiropractors (with respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function)), Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Clinical Psychologists, Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Qualified Audiologists, Registered Dietitians or Nutrition Professionals, groups or virtual groups that include one or more of these MIPS eligible clinician types.

Q. Are payments for federally qualified health center (FQHC) and rural health center (RHC) benefits subject to 2022 MIPS payment adjustments?

A: No. All professional services in FQHC and RHC benefits 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 aren't priced by the Medicare PFS.

Q: Are payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) subject to 2022 MIPS payment adjustments?

A: No, payments for DMEPOS are made according to a [separate fee schedule](#). They aren't considered covered professional services payable under the Medicare PFS.

Q: Do 2022 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 healthcare 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]
- January 13, 2020 HPMS Memo entitled "Release of 2020 MIPS Payment Adjustment Data File." This memo is available [here](#) [document title: 2020 MIPS Payment Adj Data File Release Memo 01.13.2020.pdf]

- July 10, 2020 HPMS Memo entitled: “Application of the Merit-based Incentive Payment System (MIPS) Payment Adjustment to Medicare Advantage Out-of-Network Payments – Update.” This memo is available [here](#) [See document entitled “2020 MIPS HPMS Memo 7.10.2020.pdf”]
- January 28, 2021 HPMS Memo entitled: “Release of 2021 MIPS Payment Adjustment Data File.” This memo is available [here](#) [See document entitled “2021_MIPS_Payment_Adj_Data_File_Release_Memo_01282021.pdf”]

Q: Do 2022 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 contracted clinicians by requiring specific price structures for payment. Thus, whether and how the MIPS payment adjustments might affect an MAO’s payments to its contracted 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 2022 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)?

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 isn’t 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 2022 MIPS 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 haven't 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 isn't 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 wouldn't apply to the facility payment made to the Method I CAH itself.

Q: How will 2022 MIPS payment adjustments be reflected on remittance advice (RA) documents?

A: If a 2022 MIPS payment adjustment is applied to a payment made to a MIPS eligible clinician, the following codes will be displayed on the RA⁶:

Positive MIPS Payment Adjustments	CARC⁷ 144: "Incentive adjustment, e.g., preferred product/service"	RARC⁸ N807: "Payment adjustment based on the Merit-based Incentive Payment System (MIPS)."	Group Code⁹: 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

⁶ When you submit a claim to a MAC, you'll receive a RA 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 [Remittance Advice Booklet](#).

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 can't 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 patients 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 3 months, Original Medicare¹⁰ patients receive a Medicare Summary Notice (MSN) in the mail for their Medicare Part A and Part B-covered services. [MSNs](#) show a patient 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 patient may owe the provider or supplier. For all the patient’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, Monday through Friday, 8 a.m.-8 p.m. ET or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly, please consider calling during non-peak hours—before 10 a.m. and after 2 p.m. ET.

- Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

Version History

Date	Comment
7/30/2021	Original version.

¹⁰ Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)

Appendices

Appendix A

The table below illustrates the 2020 performance category weighting and reweighting policies that CMS will apply to clinicians under MIPS. As a reminder, under § 414.1380(c), if a MIPS eligible clinician is scored on fewer than 2 performance categories (meaning one performance category is weighted at 100% or all performance categories are weighted at 0%), they'll receive a Final Score equal to the performance threshold and a neutral MIPS payment adjustment for the 2022 MIPS payment year.

MIPS Performance Category Reweighting Scenario	Quality Category Weight	Cost Category Weight	Improvement Activities Category Weight	Promoting Interoperability Category Weight
No Additional Reweighting Applies	55%	0%	15%	30%
Reweight 2 Performance Categories				
No Promoting Interoperability, No Cost	85%	0%	15%	0%
No Quality, No Cost	0%	0%	15%	85%
No Improvement Activities, No Cost	70%	0%	0%	30%

* This table may be found at § 414.1380(c)(2)(ii)(D).

Appendix B: Performance Category Weights and Payment Adjustment based on Individual Data Submission

The table below illustrates the 2020 performance category reweighting policies that CMS will apply to individual clinicians under the MIPS automatic extreme and uncontrollable circumstances policy.¹¹ The automatic policy (and the reweighting below) doesn't apply to clinicians who participate in MIPS as a group, virtual group or APM Entity.

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for 1 Performance Category					
Quality Only	100%	0%	0%	0%	Neutral
Promoting Interoperability Only	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality and Promoting Interoperability	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality and Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities and Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral
Submit Data for 3 Performance Categories					
Quality and Improvement Activities and Promoting Interoperability	55%	30%	15%	0%	Positive, Negative, or Neutral

¹¹ See 42 C.F.R. §414.1380

Appendix C: Performance Category Reweighting Scenarios

The table below identifies the performance category reweighting scenarios applicable to group and virtual group participation for the 2020 performance year.

Please note that we have updated the table to reflect the 0% reweighting of the cost performance category for everyone in the 2020 performance year.

- The quality, improvement activities, and/or Promoting Interoperability performance categories could be reweighted due to an approved EUC application.
- The Promoting Interoperability performance category could also be reweighted due to clinician type, an approved hardship exception or special status

Reweighting Scenario	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No additional reweighting from an approved EUC application, approved Promoting Interoperability hardship exception, clinician type or special status					
No Cost	55%	30%	15%	0%	Positive, Negative, or Neutral
Reweight 2 Performance Categories					
No Cost and No Promoting Interoperability	85%	0%	15%	0%	Positive, Negative, or Neutral
No Cost and No Quality	0%	85%	15%	0%	Positive, Negative, or Neutral
No Cost and No Improvement Activities	70%	30%	0%	0%	Positive, Negative, or Neutral
Reweight 3 Performance Categories					
No Quality, No Cost, No Improvement Activities	0%	100%	0%	0%	Neutral
No Quality, No Cost, No Promoting Interoperability	0%	0%	100%	0%	Neutral
No Cost, No Improvement Activities, No Promoting Interoperability	100%	0%	0%	0%	Neutral
Reweight 4 Performance Categories					
All performance categories reweighted to 0%	0%	0%	0%	0%	Neutral