



## Roadmaps

The Academy releases *Small* and *Large Practice Roadmaps* each year to help guide you through the decision-making for successful MIPS reporting. Small practices have some scoring advantages over their large practice counterparts, thus the reason for separate roadmaps. In 2024, the threshold to avoid the penalty on 2026 reimbursements from Medicare Fee For Service is a MIPS final score of 75 points.

How you earn those points depends upon which performance categories make up your MIPS score. The decisions you face depend upon how high you can score in the quality performance category and whether you qualify for the cost and promoting interoperability (PI) categories. For example, an ophthalmology practice that doesn't perform cataract surgery or melanoma resections is not likely to be subject to the cost performance category. Refer to the table on the next page as you look through your practice's roadmap.

Reweighting Scenario	Practice Size	Weighting in MIPS Final Score			
		Quality	PI	Improvement Activities	Cost
<b>No Reweighting Needed</b>					
Default weightings apply	Small or large	30%	25%	15%	30%
<b>Reweighting One Performance Category to a Zero Weight</b>					
No cost	Small or large	55%	30%	15%	0%
No promoting interoperability (PI)	Small	40%	0%	30%	30%
	Large	55%	0%	15%	30%
No quality	Small or large	0%	55%	15%	30%
No improvement activities	Small or large	45%	25%	0%	30%
<b>Reweighting Two Performance Categories to a Zero Weight</b>					
No cost, no PI	Small	50%	0%	50%	0%
	Large	85%	0%	15%	0%
No cost, no quality	Small or large	0%	85%	15%	0%
No cost, no improvement activities	Small or large	70%	30%	0%	0%
No PI, no quality	Small or large	0%	0%	50%	50%
No PI, no improvement activities	Small or large	70%	0%	0%	30%
No quality, no improvement activities	Small or large	0%	70%	0%	30%
<b>Reweighting Three Performance Categories to a Zero Weight</b>					
If CMS can only score you on one performance category, you would be assigned a MIPS final score of 75 points, which is enough to avoid the payment penalty.					

Source: 86 FR 65521 Table 63 and 86 FR 65524 2022 Final Rule

## 2024 Solo and Small-Practice Roadmap for the Merit-Based Incentive Payment System

### Step 1. Are You or Your Group Required to Report MIPS?

The clinician qualifies for an automatic exemption from MIPS if they meet one or more of the following criteria:

1. New to Medicare for 2024 and hasn't previously submitted claims under Medicare
2. Less than or equal to \$90,000 in Medicare Part B service allowed charges
3. Provides covered professional services to 200 or fewer Medicare Part B patients
4. Provides 200 or fewer covered professional services to Part B patients
  - a. When you treat more than 200 patients you are, by definition, performing at least 200 services
5. Clinician is a qualifying participant in an Advanced Alternative Payment Model.

The low volume criteria must be met in either of the following time periods to qualify for a MIPS exemption:

1. Oct 1, 2022 – Sept 30, 2023 + 30-day claims run out, and/or
2. Oct 1, 2023 - Sept 30, 2024

Verify your status online using the *QPP Participation Status Tool* (<https://qpp.cms.gov/participation-lookup>) (look under PY 2024 tab). According to CMS, the results of the first determination period were available Dec. 2023, and the results of the second determination period should be available Nov. or Dec. 2024.

- Note: If the clinician is reporting as a part of a group, the threshold is evaluated at the group level
- If the clinician is listed as a qualifying participant of an APM, they do not need to report for MIPS – although if they do, they will be covered in the event the APM does not report.

### Step 2. Are You in a Small Practice?

A small practice is defined as having 15 or fewer eligible clinicians. You can verify your status as a small practice through the online *QPP Participation Status Tool*. (<https://qpp.cms.gov/participation-lookup>)

### Step 3. Define Your Goal: Do You Want to Avoid the Penalty or Try for a Bonus?

<b><u>Goal</u></b>	<b><u>Effect on Reimbursement</u></b>	<b><u>MIPS Final Score Required</u></b>
<b>Avoid the maximum 9% Penalty</b>	Avoids the full 9% penalty on your 2026 Medicare Part B services reimbursements. (Between 18.76 and 74.99 points, the penalty is on a sliding scale, ranging from approximately 6.75% - 0.01%)	18.76 points
<b>Avoids a penalty</b>	Avoids a penalty on your 2026 Medicare Part B services reimbursements	75 points
<b>Small bonus</b>	Qualifies you for a small bonus on your 2026 Medicare Part B services reimbursements	Above 75 points

#### Step 4. How to Achieve Your Goal for the 2024 Performance Year

The MIPS final score is the weighted sum of performance category scores. For example, if a category is weighted at 30%, it contributes up to 30 MIPS final score points to the total score of up to 100 points.

<u>MIPS Performance Category</u>	<u>2024 Score Default Weight</u>
<b>Quality</b>	30%
<b>Promoting interoperability</b>	25%
<b>Improvement activities</b>	15%
<b>Cost</b>	30%

#### For those eligible for the cost performance category

- You may be eligible for the cost performance category if you perform 10 or more cataract surgeries in the performance year OR 10 or more melanoma resections in the performance year OR your practice reports at the group-level and one or more colleagues are scored on cost (because, for example, they are cataract surgeons, or you are in a multispecialty practice and a non-ophthalmology cost measure applies).

#### To Avoid a Penalty

This requires a MIPS final score of 75 points. Do *all* the following:

Improvement activities performance category:

- *If individual reporting*, complete 1 high-weighted or 2 medium-weighted improvement activities for 90+ consecutive days.
- *If group reporting*, at least 50% of eligible clinicians in your group must complete the same 1 high-weighted or 2 medium-weighted activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Quality performance category:

- Report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.
- This category must be performed for the full calendar year on 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure

AND a performance rate >0% (or <100% if an inverse measure). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.

- Review the measure achievement point benchmark table in the prep kit to make sure your choices maximize your point potential
- Bonus points: Small Practice Bonus (6 bonus points for the category)
- All small practices that report on at least one quality measure will receive 6 bonus points within the quality category
- For small practices *without* EHR:
  - Fully report (on *at least* 75% of denominator-eligible<sup>1</sup> patients to meet the data completeness threshold and providing the total eligible patient populations for the reporting period AND with *at least* 20 patients in the denominator) for all 6 quality measures.
  - You must average **7.75** quality measure points across all 6 measures (with the automatic PI hardship for small practices and assuming at least 10 points out of 30 points for the cost category).
- For small practices *with* EHR (and not taking the automatic PI hardship exception):
  - Fully report (on *at least* 75% of denominator-eligible<sup>1</sup> patients to meet the data completeness threshold AND with at least 20 patients in the denominator) for all 6 quality measures.
  - If not on the EHR 100% the entire year, provide the total eligible patient populations (CMS requires reporting on at least 75% of denominator-eligible patients to meet the data completeness threshold AND with at least 20 patients in the denominator) for all 6 quality measures.
  - The score you need will depend on how well you do in the EHR-based PI category
  - Consider reporting IRIS Registry QCDR measures that are without benchmarks in addition to your core selection. If you choose to report them, you will be assisting with the benchmarking for future years. This will give ophthalmic practices a greater selection of measures that reflect their everyday practice and can provide potentially more points than many other MIPS measures that are subject to scoring restrictions.
  - Note: If enough practices report on the IRIS Registry QCDR measures then CMS may benchmark them before your final score is released. It is possible that these could end up raising your score. *You have nothing to lose in reporting them in addition to your six core measures.*

Promoting interoperability performance category:

All small practices will receive an automatic PI exemption and have the category reweighted.

- For practices with certified electronic health record technology (CEHRT) that meet certification criteria defined by the Office of the National Coordinator for Health IT (ONC), complete the PI required measures and try to maximize your performance where possible only if you want to report and your score will be better than your quality score.

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<sup>1</sup> The IRIS Registry reports on 100% of denominator-eligible patients for IRIS Registry-EHR integrated practices.

### **For those not eligible for the cost category (the category is reweighted)**

- For group reporting, if you are in an ophthalmic only practice that is attributed with fewer than 10 routine cataract surgeries and fewer than 10 melanoma resections, your cost category score should be reweighted to the quality and PI categories. The same applies for individual reporting if you are attributed with fewer than 10 routine cataract surgeries and fewer than 10 melanoma resections. Do *all* the following:

Improvement activities performance category:

- *If individual reporting*, complete 1 high-weighted or 2 medium-weighted improvement activities for 90+ consecutive days within the 2024 performance year.
- *If group reporting*, at least 50% of eligible clinicians in your group must complete the same 1 high-weighted or 2 medium-weighted activities in any continuous 90-day period within the 2024 performance year. The clinicians do not need to share the same 90-day period.

Quality performance category:

- Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure.

For small practices *without* EHR:

- Fully report (on *at least* 75% of denominator-eligible<sup>3</sup> patients, and providing the total eligible patient populations for the reporting period AND with *at least* 20 patients in the denominator) for all 6 quality measures.
- This category must be performed for the full calendar year on 75% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
- Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
- Review the measure achievement point benchmark table to make sure your choices maximize your point potential
- Bonus points: small practice bonus (6 bonus points for the category)
- All small practices that report on at least one quality measure will receive 6 bonus points within the quality category
- You must average at least **4.0** out of 10 points on all measures assuming you are approved for the PI hardship.
- For small practices *with* EHR (and not taking the automatic PI hardship exception):
  - Fully report (on *at least* 75% of denominator-eligible<sup>2</sup> patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire reporting period AND with at least 20 patients in the denominator) for all 6 quality measures.
  - The score you need will depend on how well you do in the EHR-based PI category.

Promoting interoperability performance category:

- All small practices will receive an automatic PI hardship reweighting

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<sup>2</sup> The IRIS Registry reports on 100% of denominator-eligible patients for IRIS Registry-EHR integrated practices.

- For those practices that still want to report PI and think the PI score will be higher than their Quality score:
  - First, check if your EHR system and modules are certified for the MIPS PI performance category, please visit the Certified Health IT Product List (CHPL) on the ONC website - <https://chpl.healthit.gov/#/search>.
  - Second, for practices with certified electronic health record technology (CEHRT) that meet certification criteria defined by the Office of the National Coordinator for Health IT (ONC), complete the PI required measures and try to maximize your performance where possible.

### **Step 5: Choose your measures and/or activities.**

- Note: Each MIPS performance category can be reported on the same or on different performance periods as the other MIPS categories. However, within each MIPS category, typically all measures or activities must be reported for the same period.

#### **Improvement activities performance category:**

- Performance period: 90+ consecutive days
- To fulfill the entire improvement activities category score: complete 1 high-weighted or 2 medium-weighted improvement activities
- Each high-weighted improvement activity will count for 100% of the category score
- Each medium-weighted improvement activity will count for 50% of the category score
- Group Reporting: *At least 50%* of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.
- Note: Do not report on more activities than required to fulfill the category. CMS can audit each activity you report.
- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the Academy's website.<sup>3</sup>
- High-Weighted Improvement Activities
  - IA\_EPA\_1: Provide 24/7 Access
    - Evidence of urgent patients being seen in the practice on the same or next day
    - No EHR required
  - IA\_AHE\_1: Enhance Engagement of Medicaid and Other Underserved Populations
    - Evidence of an analysis of trends in inequities in time-to-treat data
    - Documentation of implementation of plans of activities to address inadequacies in time-to-treat performance and outcomes of these activities
    - No EHR required
  - IA\_AHE\_6: Provide Education Opportunities for New Clinicians
    - Documentation of participation as a preceptor for clinicians-in-training and clinical rotation assignments in community practices in small, underserved, or rural areas
    - No EHR required

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<sup>3</sup> [www.aao.org/medicare/improvement-activities](http://www.aao.org/medicare/improvement-activities)

- IA\_ERP\_3: COVID-19 Clinical Data Reporting With or Without Clinical Trials
  - Evidence of treatment of patients diagnosed with COVID-19 and reporting their data to a QCDR, such as the IRIS Registry
  - EHR required
- IA\_AHE\_8: Create and Implement an Anti-Racism Plan
  - Evidence of a practice-wide review and implementation of an anti-racism plan
  - No EHR required
- IA\_AHE\_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender and Queer Patients
  - Evidence of a practice-wide review and implementation of a plan to improve care for LGBTQ+ patients
  - No EHR required
- IA\_BE\_25: Drug Cost Transparency
  - Evidence of use of a real-time benefit tool and discussion of alternative medications and assistance programs
  - No EHR required
- IA\_EPA\_6: Create and Implement a Language Access Plan
  - Review of existing tools and practice, creation of a gap analysis memo, a plan to improve language access and a report with results of plan implementation
  - No EHR required
- Medium-Weighted Improvement Activities
  - IA\_CC\_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close the Referral Loop
    - Evidence that consultant sends report to referring clinician or that referring clinician has a process for capturing referral information in medical records
    - No EHR required
  - IA\_CC\_2: Implementation of Improvements That Contribute to More Timely Communication of Test Results
    - Evidence of a process that reduces time before communicating test results that includes the population identified, method of communication and benchmark for timeliness and strategies for improvement
    - No EHR required
  - IA\_AHE\_7: Comprehensive Eye Exams
    - Evidence of promotion of comprehensive eye exams and caring for underserved patients at no cost (e.g., through the Academy's EyeCare America)
    - Promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment
    - No EHR required
  - IA\_PSPA\_2: Participation in MOC Part IV
    - Evidence of participation in MOC Part IV



- No EHR required
- IA\_PSPA\_7: Use of QCDR Data for Ongoing Practice Assessments and Improvements
  - Feedback reports and documentation of how QCDR data is used for quality improvement or improvements in patient safety
  - EHR required
- IA\_AHE\_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
  - Documentation of screening tools for identifying at-risk patients and an implementation plan to advance support to patients and results achieved
  - No EHR required
- IA\_AHE\_10: Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data
  - Documentation of implementation of technology meeting security tags criteria in practice systems and clinical workflows
  - EHR required
- IA\_ERP-4: Implementation of a Personal Protective Equipment (PPE) Plan
  - Documentation of a PPE plan, including plans for conventional, contingency and crisis capacity, staff training materials and procurement or existing inventory
  - No EHR required
- IA\_ERP-6: COVID-19 Vaccine Achievement for Practice Staff
  - Evidence showing that COVID-19 vaccinations are up to date for staff according to current CDC guidelines, including standardized approach to document vaccine status, employee education and process for vaccine administration
  - EHR required
- IA\_PM\_18: Provide Clinical-Community Linkages
  - Documentation of engagement with community health workers, and coordination with primary care, and use of quality measurement and improvement processes
  - No EHR required
- IA\_PSPA\_15: Implementation of an ASP
  - Evidence of leadership of an Antimicrobial Stewardship Program (ASP) that measures appropriate use of antibiotics for several different conditions
  - No EHR required

**Quality performance category:**

Performance period: Full calendar year

Reminder: Unless you receive a hardship exception for the quality performance category, it is not possible to ensure a MIPS final score of 75 points without fully reporting on 6 quality measures.

General Quality Performance Category Information:

- This category must be performed for the full calendar year on 75% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the

denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).<sup>4</sup> CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.

- Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
- Review the measure achievement point benchmark table to make sure your choices maximize your point potential
- Bonus points: Small Practice Bonus (6 bonus points for the category)
  - All small practices that report on at least one quality measure will receive 6 bonus points within the quality category

### **Promoting interoperability performance category:**

This requires the use of Office of the National Coordinator of Health Information Technology (ONC) Certified Electronic Health Technology (CEHRT).

Performance period: 180+ consecutive days

- Note: You can only report data that is captured by ONC CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use ONC Certified CEHRT.

### How CMS Scores the Category

- Four PI objectives are required<sup>5</sup>
- To receive any credit for the category, you must meet the reporting requirements--or, where available, claim an exclusion--for all the required measures
- Some of these measures will be scored based on your performance rate
- Some measures are optional bonus measures
- Four critical attestations - To score more than 0% for PI, you must submit "Yes" for:
  - The Security Risk Analysis attestation
  - The SAFER Guides attestation
  - The Prevention of Information Blocking attestation
  - The ONC Direct Review attestation

### How to Report Measures

- You must submit all required measures or, where available, claim an exclusion to get *any* PI credit.
- For each performance rate-based measure, you must have at least *one* patient in the numerator
- Exclusion for Query of Prescription Drug Monitoring Program (PDMP)
  - A clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law OR does not electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.
- Exclusion for Support Electronic Referral Loops by Sending Health Information measure:

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<sup>4</sup> Note: CMS emphasizes that 100% of eligible patients is desired for MIPS

<sup>5</sup> The number depends on whether you report the new HIE Bi-Directional Exchange measure or the two Support Electronic Referral Loops measures

- A clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period
- Exclusion for Support Electronic Referral Loops by Receiving and Reconciling Health Information measure:
  - A clinician who receives transitions of care or referrals or has patient encounters in which the clinician has never before encountered the patient fewer than 100 times during the performance period
- Exclusion for Immunization Registry Reporting measure:
  - A clinician does not administer any immunizations to any of the populations for which data is collected by their jurisdiction OR operates in a jurisdiction where no immunization registry is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data.
- Exclusion for Electronic Case Reporting measure:
  - A clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction OR operates in a jurisdiction where no public health agency is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data.

Objective	Measures	Reporting requirement	Maximum points
<b>e-Prescribing</b>	e-Prescribing**	Numerator/denominator	10 points
	Query of Prescription Drug Monitoring Program**	Yes/No	10 points
<b>Health-information exchange</b>	Support electronic referral loops by sending health information**	Numerator/denominator	15 points
	Support electronic referral loops by receiving and reconciling health information**	Numerator/denominator	15 points
	OR	OR	OR
	HIE Bi-Directional Exchange	Yes/No	30 points
	OR	OR	OR
	Enabling Exchange under TEFCA	Yes/No	30 points
<b>Provider to Patient Exchange</b>	Provide Patients Electronic Access to Their Health Information	Numerator/denominator	25 points
<b>Public Health and Clinical Data Exchange</b>	Report the following two measures: Immunization Registry Reporting** Electronic Case Reporting**	Yes/No	25 points
	Optional measures: Clinical Data Registry reporting, OR Public Health Registry Reporting, OR Syndromic Surveillance Reporting		

IRIS Registry EHR-integrated practices qualify for the Clinical Data Registry reporting bonus measure.

\*\*Exclusions are available for the Registry measures. Check the exclusions on the measure specifications to see if you qualify.<sup>6</sup>

Measures that depend upon your performance rate will be scored by multiplying the performance rate (calculated from the numerator and denominator you submit) by the available points for the measure.

<sup>6</sup> [www.aao.org/medicare/promoting-interoperability/measures](http://www.aao.org/medicare/promoting-interoperability/measures)

## STEP 6: Submission

The January after the end of the performance year is when the submission function is activated in the *VQM Dashboard* MIPS Submission tab. You must review measures, attest and click the submit button for your information to go to CMS. Watch for announcements from the Academy and Verana Health.

### Academy and Verana Health Resources:

*Eye on Advocacy*<sup>7</sup>: This news page is updated every Thursday evening and new stories are sent to Members by the *Washington Report Express* email. It is the first place you will see any changes discussed and explained.

Academy MIPS Webpages:

<https://www.aao.org/medicare/mips>

*EyeNet*'s MIPS 2024

<https://www.aao.org/eyenet/mips>

Email IRIS Registry questions to:

[irisdatalink@veranahealth.com](mailto:irisdatalink@veranahealth.com) for registration, practice-related dashboard, mapping and MIPS submission

[irisregistry@aao.org](mailto:irisregistry@aao.org) for general issues

Email MIPS questions to:

[mips@aao.org](mailto:mips@aao.org)

AAOE e-Talk

For AAOE Members:

[https://aao.mobilize.io/users/sign\\_in/](https://aao.mobilize.io/users/sign_in/)

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<sup>7</sup> [www.aao.org/advocacy/eye-on-advocacy](https://www.aao.org/advocacy/eye-on-advocacy)

## 2023 Large Practice Roadmap for the Merit-Based Incentive Payment System

### Step 1. Are You or Your Group Required to Report MIPS?

A clinician qualifies for an automatic exemption from MIPS if they meet one or more of the following:

1. New to Medicare for 2024 and hasn't previously submitted claims under Medicare
2. Less than or equal to \$90,000 in Medicare Part B service allowed charges, and/or
3. Provides covered professional services to 200 or fewer Medicare Part B patients, and/or
4. Provides 200 or fewer covered professional services to Part B patients (When you treat more than 200 patients you are, by definition, performing at least 200 services)
5. Clinician is a Qualified Participant in an Advanced Alternative Payment Model

The low volume criteria must be met in *either* of the following time periods to qualify for a MIPS exemption:

1. Oct 1, 2022 – Sept 30, 2023 + 30-day claims run out, and/or
2. Oct 1, 2023 - Sept 30, 2024

Verify your status online using the *QPP Participation Status Tool* (<https://qpp.cms.gov/participation-lookup>) (look under 2023 tab). According to CMS, the results of the first determination period were available Dec. 2023, and the results of the second determination period should be available Nov. or Dec. 2024.

- Note: If the clinician is reporting as a part of a group, the threshold is evaluated at the group level
- If the clinician is listed as a qualified participant of an APM, they do not need to report for MIPS although if they do, they'll be covered in the event the APM does not report.

### Step 2. Are You in a Large Practice?

A large practice is defined as 16 or more eligible clinicians.

If you are in a small practice, please refer to the *Small Practice Roadmap*.

### Step 3. Define Your Goal: Do You Want to Avoid the Penalty or Try for a Bonus?

<u>Goal</u>	<u>Effect on Reimbursement</u>	<u>MIPS Final Score Required</u>
<b>Avoid the maximum 9% Penalty</b>	Avoids the full 9% penalty on your 2026 Medicare Part B services reimbursements. (Between 18.76 and 74.99 points, the penalty is on a sliding scale, ranging from approximately 6.75% - 0.01%)	18.76 points
<b>Avoids a Penalty</b>	Avoids a penalty on your 2026 Medicare Part B services reimbursements	75 points
<b>Small Bonus</b>	Qualifies you for a small bonus on your 2026 Medicare Part B services reimbursements	Above 75 points

#### Step 4. How to Achieve Your Goal for the 2024 Performance Year

The MIPS final score is the weighted sum of performance category scores. For example, if a category is weighted at 30%, it contributes up to 30 MIPS final score points to the total score of up to 100 points.

<u>MIPS Performance Category</u>	<u>2024 Score Weight</u>
<b>Quality</b>	30%
<b>Promoting interoperability</b>	25%
<b>Improvement activities</b>	15%
<b>Cost</b>	30%

#### To Avoid a Penalty

This requires MIPS final score of 75 points. Do *all* the following:

Improvement activities performance category:

- Complete 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted improvement activities for 90+ consecutive days.
- *If group reporting*, at least 50% of eligible clinicians in your group must Complete 2 high-weighted OR 4 medium-weighted OR 1 high-weighted and 2 medium-weighted improvement activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Quality performance category:

- Report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.
- Report each quality measure:
  - For the full calendar year<sup>8</sup>; and
  - On *at least 75%* of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire reporting period; and with *at least 20* patients in the denominator
  - Consider reporting IRIS Registry QCDR measures that are without benchmarks in addition to your core selection. If you choose to report them, you will be assisting with the

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<sup>8</sup> The IRIS Registry allows you to report from the beginning of the year.

benchmarking for future years. This will give ophthalmic practices a greater selection of measures that reflect their everyday practice and can provide potentially more points than many other MIPS measures that are subject to scoring restrictions.

- Note: If enough practices report on the IRIS Registry QCDR measures, then CMS may benchmark them before your final score is released. It is possible that these could end up raising your score. *You have nothing to lose in reporting them in addition to your six core measures.*

Promoting interoperability performance category:

- With the Office of the National Coordinator for Health Information Technology (ONC) Certified EHR Technology (CEHRT), complete the PI required measures and try to maximize your performance where possible

### **Step 5: Choose your measures and/or activities.**

Note: Each MIPS category can be reported on the same or on different performance periods as the other MIPS categories. However, within each MIPS category, typically all measures or activities must be reported for the same period.

#### **Improvement activities performance category:**

- Performance period: 90+ consecutive days
- To fulfill the entire improvement activities category score: complete 1 high-weighted or 2 medium-weighted improvement activities
- Each high-weighted improvement activity will count for 100% of the category score
- Each medium-weighted improvement activity will count for 50% of the category score
- Group Reporting: *At least 50%* of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.
- Note: Do not report on more activities than required to fulfill the category. CMS can audit each activity you report.

The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the Academy's website.<sup>9</sup>

- High-Weighted Improvement Activities
  - IA\_EPA\_1: Provide 24/7 Access
    - Evidence of urgent patients being seen in the practice on the same or next day
    - No EHR required
  - IA\_AHE\_1: Enhance Engagement of Medicaid and Other Underserved Populations
    - Evidence of an analysis of trends in inequities in time to treat data
    - Documentation of implementation of plans of activities to address inadequacies in time to treat performance and outcomes of these activities
    - No EHR required
  - IA\_AHE\_6: Provide Education Opportunities for New Clinicians
    - Documentation of participation as a preceptor for clinicians-in-training and clinical rotation assignments in community practices in small, underserved, or rural areas

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<sup>9</sup> [www.aao.org/medicare/improvement-activities](http://www.aao.org/medicare/improvement-activities)



- No EHR required
- IA\_ERP\_3: COVID-19 Clinical Trials
  - Evidence of treatment of patients diagnosed with COVID-19 and reporting their data to a QCDR, such as the IRIS Registry
  - EHR required
- IA\_AHE\_8: Create and Implement an Anti-Racism Plan
  - Evidence of a practice-wide review and implementation of an anti-racism plan
  - No EHR required
- IA\_AHE\_11: Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender and Queer Patients
  - Evidence of a practice-wide review and implementation of a plan to improve care for LGBTQ+ patients
  - No EHR required
- IA\_BE\_25: Drug Cost Transparency
  - Evidence of use of the Real-Time Benefit Tool and discussion of alternative medications and assistance programs
  - No EHR required
- IA\_EPA\_6: Create and Implement a Language Access Plan
  - Review of existing tools and practice, creation of a gap analysis memo, a plan to improve language access and a report with results of plan implementation
  - No EHR required
- Medium-Weighted Improvement Activities
  - IA\_CC\_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close the Referral Loop
    - Evidence that consultant sends report to referring clinician or that referring clinician has a process for capturing referral information in medical record
    - No EHR required
  - IA\_CC\_2: Implementation of Improvements That Contribute to More Timely Communication of Test Results
    - Evidence of a process that reduces time before communicating test results that includes the population identified, method of communication and benchmark for timeliness and strategies for improvement
    - No EHR required
  - IA\_AHE\_7: Comprehensive Eye Exams
    - Evidence of promotion of comprehensive eye exams and caring for underserved patients at no cost (e.g., through the Academy's EyeCare America)
    - Promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment
    - No EHR required

- IA\_PSPA\_2: Participation in MOC Part IV
  - Evidence of participation in MOC Part IV
  - No EHR required
- IA\_PSPA\_7: Use of QCDR Data for Ongoing Practice Assessments and Improvements
  - Feedback reports and documentation of how QCDR data is used for quality improvement or improvements in patient safety
  - EHR required
- IA\_AHE\_9: Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
  - Documentation of screening tools for identifying at-risk patients and an implementation plan to advance support to patients and results achieved
  - No EHR required
- IA\_AHE\_10: Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data
  - Documentation of implementation of technology meeting security tags criteria in practice systems and clinical workflows
  - EHR required
- IA\_ERP-4: Implementation of a Personal Protective Equipment (PPE) Plan
  - Documentation of a PPE plan, including plans for conventional, contingency and crisis capacity, staff training materials and procurement or existing inventory
  - No EHR required
- IA\_ERP-6: COVID-19 Vaccine Achievement for Practice Staff
  - Evidence showing that COVID-19 vaccinations are up to date for staff according to current CDC guidelines, including standardized approach to document vaccine status, employee education and process for vaccine administration
  - EHR required
- IA\_PM\_18: Provide Clinical-Community Linkages
  - Documentation of engagement with community health workers, and coordination with primary care, and use of quality measurement and improvement processes
  - No EHR required
- IA\_PSPA\_15: Implementation of an ASP
  - Evidence of leadership of an Antimicrobial Stewardship Program (ASP) that measures appropriate use of antibiotics for several different conditions
  - No EHR required

**Quality Performance Category:**

- Performance period: Full calendar year
- Reminder: Unless you receive a hardship exception for the quality performance category, it is not possible to ensure a MIPS final score of 75 points without fully reporting on 6 quality measures

### General Quality Category Information:

- This category must be performed for the full calendar year on 75% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the denominator for each measure AND a performance rate >0 (or <100 if an inverse measure). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
- Report on at least 6 quality measures, 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
- Review the measure achievement point benchmark table to make sure your choices maximize your point potential

### Promoting interoperability performance category:

- This requires the use of ONC Certified EHR Technology (ONC CEHRT)
- Performance period: 180+ consecutive days
  - Note: You can only report data that is captured by ONC CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use ONC CEHRT.
- How CMS Scores the Category
  - Four PI objectives are required<sup>10</sup>
  - To receive any credit for the category, you must meet the reporting requirements--or, where available, claim an exclusion--for all the required measures
  - Some of these measures will be scored based on your performance rate
  - Some measures are optional bonus measures
  - Four critical attestations - To score more than 0% for PI, you must submit "Yes" for:
    - The Security Risk Analysis attestation
    - The SAFER Guides attestation
    - The Prevention of Information Blocking attestation
    - The ONC Direct Review attestation

### How to Report Measures

- You must submit all required measures to get *any* PI credit
- For each performance rate-based measure, you must have at least *one* patient in the numerator
  - Exclusion for Query of Prescription Drug Monitoring Program (PDMP)
    - A clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs OR writes fewer than 100 permissible prescriptions during the performance period, OR querying a PDMP would impose an excessive workflow or cost burden prior to start of performance period.
  - Exclusion for Support Electronic Referral Loops by Sending Health Information measure:
    - A clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

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<sup>10</sup> The number depends on whether you report the new HIE Bi-Directional Exchange measure or the two Support Electronic Referral Loops measures

- Exclusion for Support Electronic Referral Loops by Receiving and Reconciling Health Information measure:
  - A clinician who receives transitions of care or referrals or has patient encounters in which the clinician has never before encountered the patient fewer than 100 times during the performance period.
- Exclusion for Immunization Registry Reporting measure:
  - A clinician does not administer any immunizations to any of the populations for which data is collected by their jurisdiction OR operates in a jurisdiction where no immunization registry is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data.
- Exclusion for Electronic Case Reporting measure:
  - A clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction OR operates in a jurisdiction where no public health agency is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data.

## Promoting Interoperability Performance Category Objectives and Measures

Objective	Measures	Reporting requirement	Maximum points
<b>e-Prescribing</b>	e-Prescribing**	Numerator/denominator	10 points
	Query of Prescription Drug Monitoring Program**	Yes/No	10 points
<b>Health-information exchange</b>	Support electronic referral loops by sending health information**	Numerator/denominator	15 points
	Support electronic referral loops by receiving and reconciling health information**	Numerator/denominator	15 points
	OR	OR	OR
	HIE Bi-Directional Exchange	Yes/No	30 points
	OR	OR	OR
	Enabling Exchange under TEFCA	Yes/No	30 points
<b>Provider to Patient Exchange</b>	Provide Patients Electronic Access to Their Health Information	Numerator/denominator	25 points
<b>Public Health and Clinical Data Exchange</b>	Report the following two measures: Immunization Registry Reporting** Electronic Case Reporting**	Yes/No	25 points
	Optional measures: Clinical data registry reporting, OR Public health registry reporting, OR Syndromic surveillance reporting		

IRIS Registry EHR-integrated practices qualify for the Clinical Data Registry reporting bonus measure for 5 points.

\*\*Exclusions are available for these 2 measures. Check the exclusions on the measure specifications to see if you qualify.<sup>11</sup>

Measures that depend upon your performance rate will be scored by multiplying the performance rate (calculated from the numerator and denominator you submit) by the available points for the measure.

<sup>11</sup> [www.aao.org/medicare/promoting-interoperability/measures](http://www.aao.org/medicare/promoting-interoperability/measures)

## STEP 6: Submission

The January after the end of the performance year is when the submission function is activated in the *VQM Dashboard* MIPS Submission tab. You must review measures, attest and click the submit button for your information to go to CMS. Watch for announcements from the Academy.

### Academy Resources:

*Eye on Advocacy*<sup>12</sup>: This news page is updated every Thursday evening and new stories are sent to members by the *Washington Report Express* email. It is the first place you will see any changes discussed and explained.

Academy MIPS Webpages:

[www.aao.org/medicare/mips](http://www.aao.org/medicare/mips)

*EyeNet's* MIPS 2024

[www.aao.org/eyenet/mips](http://www.aao.org/eyenet/mips)

Email IRIS Registry questions to:

[irisdatalink@veranahealth.com](mailto:irisdatalink@veranahealth.com) for registration, practice-related dashboard, mapping and MIPS submission

[irisregistry@aao.org](mailto:irisregistry@aao.org) for general issues

Email MIPS questions to:

[mips@aao.org](mailto:mips@aao.org)

AAOE e-Talk

For AAOE Members:

[https://aao.mobilize.io/users/sign\\_in](https://aao.mobilize.io/users/sign_in)

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<sup>12</sup> [www.aao.org/advocacy/eye-on-advocacy](http://www.aao.org/advocacy/eye-on-advocacy)