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SUPPLEMENT

MIPS 2023: A Primer and Reference

Published May 2023

Your Guide to MIPS, Including:

- Bonuses and Penalties (Table 1)
- Scoring Examples (Table 2)
- 52 Quality Measures (Table 4)
- Promoting Interoperability (Tables 5-6)
- 66 Improvement Activities (Tables 7-8)

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Reference: 1. Data on file. Regeneron Pharmaceuticals, Inc.

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MAKE SURE YOUR TEAM HAS WHAT IT NEEDS

Succeed at MIPS in 2023

This supplement is designed to help ophthalmology practices navigate the rules of the "traditional" Merit-Based Incentive Payment System (MIPS). It doesn't cover nuances that only apply to the new MIPS Value Pathways (see page 72).

Get on Track with 2023 MIPS

Who is on your MIPS team? Your practice should have a MIPS point person and—in case of illness or turnover—at least one backup. A MIPS physician champion should be responsible for ensuring that those MIPS staff have the resources and, importantly, the time that they need.

Don't make assumptions about MIPS status. The MIPS point person should check whether each of the practice's clinicians is a MIPS eligible clinician and can do so using the QPP Participation Status tool (see page 16). Also use this tool to check other MIPS designations, such as practice size.

Have clinicians joined or left your practice? CMS determines practice size based on the information that it has in its Provider Enrollment, Chain, and Ownership System (PECOS). To check that the information is current, visit the PECOS portal at https://pecos.cms.hhs.gov.

Is your 2023 MIPS performance on track? You should already have picked a quality reporting option (see page 19) and know which quality measures you are reporting. Has your practice decided whether its clinicians are reporting as individuals or as a group? If the latter, make sure that all clinicians know which quality measures (see page 26) and improvement activities (see page 53) your group plans to report. If reporting promoting interoperability (PI), read "How to Boost Your Promoting Interoperability Score" (*EyeNet*, August 2021) at aao.org/eyenet/archive.

Reporting MIPS via the IRIS Registry? Check the *IRIS Registry Preparation Kit* (see "Empower Your MIPS Team") for schedules of what needs to be done throughout the year. You can start by making sure that the IRIS Registry has the most up-to-date information on your practice and its providers. For example, make sure the IRIS Registry knows whether any new clinicians have joined your practice, whether any of your clinicians don't have to take part in MIPS, or if any clinicians decide to opt-in to MIPS even though a low-volume exclusion applies.

Need IRIS Registry support? Got a technical question about IRIS Registry–EHR integration? Log in to your practice's IRIS Registry account and submit a ticket via Verana Support.

If you are doing manual reporting via the IRIS Registry, you will still be working with the original vendor, FIGmd, and can submit a help desk ticket to them (aao.org/iris-registry/user-guide/submit-help-desk-ticket).

Speed up IRIS Registry communications. Whenever you contact the IRIS Registry or its vendors, make sure you include your practice's name and its IRIS Registry ID. Watch for emails from Verana Health and FIGmd, the IRIS Registry vendors that are responsible for EHR-based and manual-based reporting, respectively.

Empower Your MIPS Team

Can your MIPS team access these key MIPS resources? You need to be a member of the Academy and/or the AAOE to access these ophthalmology-specific MIPS materials:

- **The Academy's MIPS hub page** (aao.org/medicare/mips) features "road maps," detailed measure specifications, and more.
- ***The IRIS Registry Preparation Kit*** (aao.org/iris-registry/user-guide/getting-started) walks you through some key steps of MIPS reporting, and also offers "road maps," schedules of what needs to be done throughout the year, measure specifications, MIPS tips, and more. It is more than 500 pages long. Download it for free or buy a print version from the Academy store.
- ***EyeNet's* 2023 MIPS supplement** (aao.org/eyenet/mips-manual-2023) was posted online ahead of print.
- **Academy and AAOE e-bulletins** provide the latest MIPS news. Check your inbox for *Washington Report Express* (Thursdays), *Medicare Physician Payment Update* (first Saturday of the month), and—if you are an AAOE member—*Practice Management Express* (Sundays).
- **AAOE-Talk.** AAOE members can use this online community to share MIPS tips. Go to aao.org/practice-management/aaoe-talk-overview. Not an AAOE member? Join at aao.org/member-services/join-aaoe.

PARTNERSHIP INCLUDES EHR DATA INTEGRATION

Verana Health and the IRIS Registry

Verana Health is now the Academy's exclusive end-to-end data partner for the IRIS Registry. If you report 2023 MIPS via IRIS Registry–EHR integration, you will do so via the Verana Quality Measures (VQM) Dashboard.

Transitioning From FIGmd to Verana Health

IRIS Registry–EHR integration has proven to be the least burdensome way to report MIPS quality measures. After completing the integration process, practices can use a dashboard to track their performance on the quality measures that they plan to submit. When the MIPS program started in 2017, FIGmd was the company that helped practices with this integration process and provided a dashboard for MIPS reporting. Last year, Verana Health started taking over that role from FIGmd. This transition has been rolled out based on the EHR system that each practice uses—but certain systems are not eligible for the transition (see below).

Some practices reported 2022 MIPS using Verana Health's VQM Dashboard. Verana Health supported some practices with their 2022 MIPS reporting via its VQM Dashboard, but most IRIS Registry–EHR integrated practices reported MIPS via their original FIGmd dashboard.

Moving to the VQM Dashboard for 2023 MIPS reporting. After 2022 MIPS reporting was completed in March, Verana Health was able to resume the transition process and—as of April 1, 2023—most IRIS Registry–EHR integrated practices no longer have an active FIGmd dashboard. If you have not yet completed onboarding to the VQM Dashboard, be on the lookout for email communications from the Verana Health Practice Experience Management team.

Not heard from Verana Health? If you have not yet heard from Verana Health regarding your dashboard, it may be because the contact information for your practice has not been updated. If you think that might be the case, please email irisdatalink@veranahealth.com.

Reminder: EHR System Integration Eligibility

To deliver optimal value to Academy members, the IRIS Registry must be able to aggregate valid data from secure and reliable EHR systems that share comprehensive data in a timely and well-organized manner.

Ophthalmology's most common EHR systems meet Verana Health's integration standards. For EHR systems that are used by the vast majority of ophthalmic practices, Verana Health's integration efforts have been highly successful.

A few EHR systems don't meet Verana Health's requirements. Some of the less common EHR systems do not meet Verana Health's minimum criteria for IRIS Registry–EHR integration. For example, some EHR systems yield insufficient data to accurately calculate MIPS quality measures and provide practices with meaningful performance feedback. Such EHR systems will not be integrated by Verana Health.

As a reminder, if your EHR system does not meet the minimum criteria for transitioning to the VQM Dashboard, you will need to switch to an eligible EHR system to continue participating in the IRIS Registry.

To view the list of eligible EHR systems, visit aao.org/iris-registry/ehr-systems.

Reporting Quality Measures Manually Via the IRIS Registry?

2023 is the last year for reporting quality measures manually via the IRIS Registry. For MIPS performance year 2023, the Academy and its IRIS Registry partner, Verana Health, are again providing the option to report MIPS manually via the IRIS Registry using the vendor FIGmd. However, you won't be able to do so for 2024. Why the change? Although the IRIS Registry was widely used to manually report quality measures for PQRS and for the initial years of MIPS, its use for non-EHR reporting has now dwindled. Furthermore, CMS has said that it will—sooner or later—make electronic reporting the only option for MIPS.

Consider implementing an EHR system ahead of 2024. As a first step in adopting an EHR system, check which of them can be integrated with the IRIS Registry (aao.org/iris-registry/ehr-systems) and also review EHR resources offered by the AAOE (aao.org/practice-management/electronic-health-records/ehrs).

Other options. It is expected that you will still be able to report quality measures via claims in 2024. Or you can select another registry to submit quality measures manually.

KNOW THE BASICS

Your 2025 MIPS Payment Adjustment

Under MIPS, future Medicare Part B reimbursement is subject to a payment adjustment based on current clinician performance, with your *2023* MIPS final score determining whether your *2025* payment adjustment is positive (a bonus), neutral (no adjustment), or negative (a penalty), as shown below.

Determining the Payment Adjustment

The performance threshold is 75 points. Earn a bonus by scoring more than 75 points; incur a penalty by scoring fewer.

The penalties are known. If your MIPS final score is 18.75 points or lower, you will incur the maximum –9% penalty; if you score between 18.75 and 75 points, your payments will be reduced as shown in Table 1B.

The bonuses aren't yet known. The bonuses will be funded by payment penalties. Consequently, CMS can't estimate how much money is in the bonus pool—and how many clinicians will be entitled to money from that pool—until it has calculated the final scores of all MIPS participants, which can't happen until the performance year is over. To date, bonuses have been quite small.

Why is there a gap year between performance (2023) and payment adjustments (2025)? CMS needs time to process clinicians' MIPS data, determine MIPS final scores, perform targeted reviews, and calculate what the adjustment factors for bonuses will need to be in order to ensure budget neutrality.

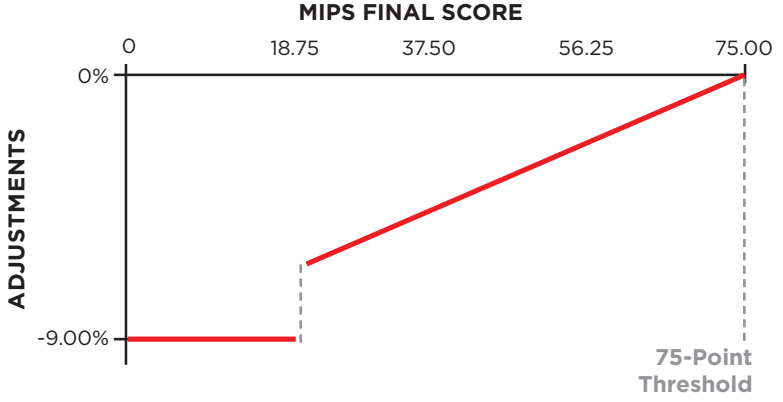
Each summer, check how CMS has scored your previous year's performance. You will be able to view performance feedback and your payment adjustment information when you log in to the CMS website (qpp.cms.gov/login). Check the payment adjustment information carefully. If you note any scoring errors, you can request a targeted review, but you should act swiftly. Once the final performance feedback is released, you only have 60 days to request a targeted review.

Table 1A: Bonuses and Penalties

2023 MIPS Final Score	2025 Payment Adjustment
0-18.75 points	Maximum penalty of –9%
18.76-74.99 points	Penalty on a sliding scale (see Table 1B)
75 points	Neutral (no penalty, no bonus)
75.01-100 points	Bonus on a sliding scale

Table 1B: Payment Penalty

If your 2023 MIPS final score is less than the 75-point performance threshold, your 2025 Medicare Part B payments will be reduced as shown below.



Applying the Payment Adjustment

In 2025, CMS will start applying a payment adjustment that will be based on your 2023 MIPS final score. This will be applied throughout 2025 to your Medicare Part B remittances.

Your payment adjustments are always applied at the TIN/NPI level. CMS will apply the 2025 MIPS payment adjustment to individual clinicians, and it will do so regardless of whether you participated in 2023 MIPS as an individual or as part of a group that pooled its MIPS data. CMS uses Taxpayer Identification Numbers (TINs) and National Provider Identifiers (NPIs) to identify individuals (see page 16).

What if you move to another practice after 2023 is over? Your 2023 MIPS final score will determine your 2025 payment adjustment, and this is the case even if you move to a new practice after the 2023 performance year.

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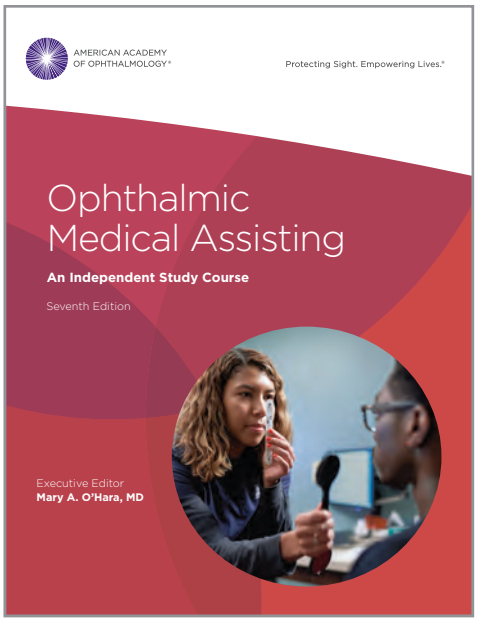

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KNOW THE BASICS

Your 2023 MIPS Final Score

Your 2023 MIPS final score determines how CMS will adjust payments for your Medicare Part B services in 2025, as discussed on page 9.

Understand MIPS scoring. Read this section to learn how the MIPS performance category scores are factored into your MIPS final score. Next, ascertain which performance categories you think you'll be scored on and turn to the relevant sections of this supplement to see how each of those are scored.

How CMS Calculates Your MIPS Final Score

Your MIPS final score can range from 0 to 100 points. It is based on your weighted scores in up to four performance categories and can be topped up with the complex patient bonus, which is discussed below.

You are scored on up to four performance categories. CMS will try to assign you scores for each of the following performance categories:

- quality—you are scored on your performance rates for up to six quality measures (e.g., measure 117: Diabetes: Eye Exam)
- promoting interoperability (the EHR-based performance category)—you are scored based on your performance rate for some measures (e.g., the e-Prescribing measure) and get a flat score for other measures (e.g., the Clinical Data Registry Reporting measure)
- improvement activities—you earn a flat score for each activity (e.g., IA_AHE_6: Provide education opportunities for new clinicians)
- cost—you don't need to do any reporting for this performance category; instead, CMS uses administrative claims data to score you on cost measures (e.g., the Routine Cataract Removal With IOL Implantation measure)

How your performance category scores are weighted. The *default* weights of your performance category scores are as follows:

- quality's weight—30%
- promoting interoperability's weight—25%
- improvement activities' weight—15%
- cost's weight—30%

What the weights mean. If your quality score's weight is 30%, it can contribute up to 30 points to your MIPS final score. For example, a quality score of 50% would contribute 15 points (50% of 30 points).

Get up to 10 bonus points for patient complexity. If you report MIPS data for at least one performance category, you may be eligible for a complex patient bonus. CMS determines the complex patient bonus based on two indicators:

- the average Hierarchical Condition Category (HCC) risk score of your patients; and
- a dual eligible ratio, which is based on the proportion of beneficiaries eligible for both Medicare and Medicaid.

Will you get a complex patient bonus? You will be eligible for the complex patient bonus only if you have at least a median score for the HCC risk indicator and/or for the dual eligible ratio.

Calculating your MIPS final score. Your MIPS final score is the sum of your weighted performance category scores (0-100 points) plus your complex patient bonus (0-10 points). It is capped at 100 points.

Reweighting Your Performance Categories

If CMS determines that you should not be scored on a performance category, it can reduce that category's weight in your MIPS final score to zero and increase the weight of one or more of the other performance categories accordingly (see Table 3, page 14).

When does CMS reweight performance categories? Reweighting may occur in the following circumstances.

When you can't be scored on any cost measures. If you are not a cataract surgeon or an oculofacial specialist, you are unlikely to meet the case minimum for any measures in the cost performance category. And if you can't be scored on any cost measures, the cost score's weight in your MIPS final score will be redistributed to one or more of the other performance categories as shown in Table 3. (To learn more about the cost measures, see page 70.)

When "extreme and uncontrollable" circumstances apply. You can apply to have performance categories reweighted if your ability to perform one or more of them is limited by extreme circumstances that are beyond your control. And in a widespread catastrophe, such as a hurricane, CMS may automatically apply reweighting to individual clinicians who are in the affected area. (To learn more about the extreme and uncontrollable circumstances exceptions, see page 17.)

When a promoting interoperability exception applies. If you are in a small practice (see "Small or Large Practice?" on page 16), your promoting interoperability score will auto-

matically be reweighted to zero. This automatic reweighting also applies to certain clinician types, but none of them is likely to be employed in an ophthalmology practice. And CMS has specified certain circumstances in which you can apply for a promoting interoperability exception—including, for example, if your EHR system was recently decertified. (To learn more about the promoting interoperability exceptions, see page 48.)

Warning—by submitting data, you can override a CMS decision to reweight performance categories. Suppose, for example, CMS accepts your application for a promoting interoperability significant hardship exception. If you submit promoting interoperability data for MIPS, you will be waiving your right to that exception. CMS will assume that you want to be scored on that performance category and will factor your promoting interoperability score into your MIPS final score.

You'll Be Scored on How You Do During Performance Periods of 90 to 365 Days

Depending on the performance category, your performance period can vary from 90 days to the full year. The perfor-

Table 2: Scoring Examples

How does CMS calculate a clinician's MIPS final score? Let's suppose a clinician scores 70% for quality, 88% for promoting interoperability (PI), 100% for improvement activities (IA), and 60% for cost. Table 2A shows the clinician's MIPS final score if the default weights apply.

What if CMS decides that the clinician shouldn't be scored on PI and/or cost? Tables 2B and 2C show how reweighting of the performance categories affects the MIPS final score if the clinician is in a small or large practice, respectively. (For other reweighting scenarios, see Table 3, page 14.)

Table 2A: When Default Weights Apply

Performance Category Score	Weight	Points Calculation	Points in Final Score
Quality score: 70%	30%	70% of 30 points =	21 points
PI score: 88%	25%	88% of 25 points =	22 points
IA score: 100%	15%	100% of 15 points =	15 points
Cost score: 60%	30%	60% of 30 points =	18 points
		MIPS final score* =	76 points

Table 2B: When Reweighting Applies to a *Small* Practice

Performance Category Score	Weight	Points Calculation	Points in Final Score
Reweighting Scenario: PI Reweighted to Zero			
Quality score: 70%	40%	70% of 40 points =	28 points
IA score: 100%	30%	100% of 30 points =	30 points
Cost score: 60%	30%	60% of 30 points =	18 points
		MIPS final score* =	76 points
Reweighting Scenario: Cost Reweighted to Zero			
Quality score: 70%	55%	70% of 55 points =	38.5 points
PI score: 88%	30%	88% of 30 points =	26.4 points
IA score: 100%	15%	100% of 15 points =	15 points
		MIPS final score* =	79.9 points
Reweighting Scenario: PI and Cost Reweighted to Zero			
Quality score: 70%	50%	70% of 50 points =	35 points
IA score: 100%	50%	100% of 50 points =	50 points
		MIPS final score* =	85 points

* This score doesn't take into account a possible complex patient bonus, which could add up to 10 points.

mance period for each of the four performance categories must take place between Jan. 1, 2023, and Dec. 31, 2023. Its length depends on the category:

- quality—12 months (full calendar year)
- promoting interoperability—90 consecutive days or longer (up to the full calendar year)
- improvement activities—typically 90 consecutive days or longer (up to the full calendar year)
- cost—12 months (full calendar year)

You don't have to tackle promoting interoperability measures and improvement activities at the same time. Each of those two performance categories could have a different performance period. For example, you could pick June-August for improvement activities and September-November for promoting interoperability—but you would need to perform all your improvement activities within that June-August time frame and all your scored promoting interoperability measures within that September-November time frame, though they could also extend beyond that period.

You Can Be Scored at the Individual- and/or Group-Level

You can report and be scored as an individual and/or as part of a group. If you are scored as an individual, CMS will use both your Taxpayer Identification Number (TIN) and your National Provider Identifier (NPI) to distinguish you as a unique MIPS participant (see "Use of TINs and NPIs as Identifiers," page 16). If you and your colleagues report as a group, the group's TIN will be used as your identifier for scoring purposes. You also can report both ways and see which approach scores higher (see "Participate as an Individual or as a Group?" on page 17).

Reporting as a group? If your practice is reporting an improvement activity as a group, at least half of the group must perform the activity for 90 or more days, but they can each pick their own date range of 90 days or more. If reporting promoting interoperabilty as a group, you would aggregate data from all the group's MIPS eligible clinicians who have data in the practice's certified EHR technology (CEHRT).

Special Circumstances: When Clinicians Join a Practice Late in the Year

If you join a practice in the last three months of 2023, CMS will assume that you won't have enough measures available to you to participate in MIPS as an individual at that practice. What does this mean for your score at that practice? If you join a newly formed practice (established after Oct. 1, 2023) or if you join an established practice where the clinicians are reporting as individuals, CMS will award you a MIPS final score of 75 points, which is this year's performance threshold, meaning that you would get a neutral payment adjustment in 2025. But if you join an established practice that is reporting as a group and that includes your NPI in its group-level reporting, you would get its group score; your data after you join should be included in its group reporting.

Table 2: Scoring Examples (Continued)

Table 2C: Scoring Examples When Reweighting Applies to a *Large* Practice

Performance Category Score	Weight	Points Calculation	Points in Final Score
Reweighting Scenario: PI Reweighted to Zero			
Quality score: 70%	55%	70% of 55 points =	38.5 points
IA score: 100%	15%	100% of 15 points =	15 points
Cost score: 60%	30%	60% of 30 points =	18 points
		MIPS final score* =	71.5 points
Reweighting Scenario: Cost Reweighted to Zero			
Quality score: 70%	55%	70% of 55 points =	38.5 points
PI score: 88%	30%	88% of 30 points =	26.4 points
IA score: 100%	15%	100% of 15 points =	15 points
		MIPS final score* =	79.9 points
Reweighting Scenario: PI and Cost Reweighted to Zero			
Quality score: 70%	85%	70% of 85 points =	59.5 points
IA score: 100%	15%	100% of 15 points =	15 points
		MIPS final score* =	74.5 points

* This score doesn't take into account a possible complex patient bonus, which could add up to 10 points.

Table 3: How the Performance Categories Are Weighted

Your MIPS final score (0-100 points) is a composite score. Your MIPS final score is based on up to four performance category scores, which are weighted as shown below. For example, if quality is weighted at 30%, it contributes up to 30 points to your MIPS final score.

You may qualify to have performance categories reweighted. When calculating your MIPS final score, CMS may reweight performance categories if extreme and uncontrollable circumstances apply (see page 17), if a promoting interoperability (PI) exception applies (page 48), or if you don't meet the case minimum for any cost measures.

Reweighting may depend on practice size. In some circumstances, your practice size (see "Small or Large Practice?" page 16) will impact how CMS reweights your performance categories.

Reweighting Scenarios	Practice Size	Weighting in MIPS Final Score			
		Quality	PI	Improvement Activities	Cost
No Reweighting Needed					
Default weightings apply	Small or large	30%	25%	15%	30%
Reweighting One Performance Category to a Zero Weight					
No cost	Small or large	55%	30%	15%	0%
No 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%
Reweighting Two Performance Categories to a Zero Weight					
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%
Reweighting Three Performance Categories to a Zero Weight					
If CMS can score you on only one performance category, you would be assigned a MIPS final score of 75 points, which is enough to avoid the payment penalty (see Table 1, page 9).					

KNOW THE BASICS

Your MIPS Participation Status

Many aspects of your MIPS participation status are determined by CMS. For example: Are you eligible to participate in MIPS? Do you qualify for a MIPS exclusion? Is your practice deemed to be small or large?

But another important aspect of your MIPS status—whether you want to participate as an individual or as part of a group—is up to you and your practice.

Who Does (and Doesn't) Take Part in MIPS

Understand two related terms—*eligible clinicians* and *MIPS eligible clinicians.* Under the Quality Payment Program, which includes an advanced alternative payment model (APM) pathway and a MIPS pathway, certain clinicians are classified as *eligible clinicians*, and a subset of those—those classified as *MIPS eligible clinicians*—take part in MIPS.

If you are an eligible clinician, CMS will count you when it is determining practice size regardless of whether or not you are a MIPS eligible clinician (see "Small or Large Practice?" on next page).

Who are the *eligible clinicians*? You are considered an eligible clinician if 1) you have a unique TIN/NPI combination (for more on Tax Identification Numbers and National Provider Identifiers, see "Use of TINs and NPIs as Identifiers," page 16) and 2) you fall within one of these clinician types:

- physicians,
- optometrists,
- 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,
- certified nurse midwives, and
- clinical social workers.

Who are the *MIPS eligible clinicians*? You are considered a MIPS eligible clinician if:

- you are an eligible clinician and none of the exclusions (see below) apply to you, or
- you are an eligible clinician who decides to "opt in" to MIPS even though you fall below one or two (but not all three) of the low-volume thresholds (see "Exclusion 2," below).

(Note: When the MIPS regulations use the term MIPS eligible clinician, it doesn't just refer to individuals, it can also refer to a group that includes such an individual.)

MIPS Exclusions

Are you exempt from MIPS? You may be exempt from MIPS if at least one of the following three exclusions applies.

Exclusion 1—eligible clinicians new to Medicare. If you enroll in Medicare for the first time in 2023 and you have not previously submitted claims under Medicare, you will be exempt from the MIPS rules for the 2023 performance year.

Exclusion 2—eligible clinicians who are below the low-volume threshold. You will be exempt from MIPS if, during either of two 12-month time segments (see "MIPS Determination Period," at left), you:

- have allowed charges for covered Medicare Part B professional services of $90,000 or less; or
- provide covered professional services to no more than 200 Medicare Part B beneficiaries; or
- provide 200 or fewer covered professional services to Part B beneficiaries. (Note: If you see one beneficiary one time, that counts as one service; if you see a second patient five times, that would count as another five services.)

The difference between the second and third low-volume criteria can become significant when determining which low-volume clinicians can opt in to MIPS (see next page).

Two chances to meet the requirements of a low-volume exclusion. The fact that the MIPS determination period is

MIPS Determination Period

The MIPS determination period is a 24-month assessment period. It consists of two time segments; for the 2023 performance year, these are as follows:

- Oct. 1, 2021-Sept. 30, 2022 (with 30-day claims run out)
- Oct. 1, 2022-Sept. 30, 2023 (no claims run out)

Why the MIPS determination period matters. CMS uses data from these two time segments to determine whether clinicians fall under any of the low-volume thresholds (see "Exclusion 2") and to see whether a practice should be assigned a special status, such as small practice (see next page) or rural practice (see page 51).

composed of two time segments means that you have two chances to qualify for a low-volume exclusion: If you fall below the low-volume threshold for one time segment, you will be eligible for an exclusion—even if you exceed the threshold in the other time segment.

Low-volume threshold determinations are made at the individual level and at the group level. You could fall below the low-volume threshold at the individual-reporting level but would not be exempt from MIPS if reporting as part of a group that exceeds that threshold at the group level.

Exclusion 3—eligible clinicians who are qualifying participants (QPs) in advanced APMs. If you are participating in an advanced APM, you may be exempt from the MIPS rule if you satisfy the APM track's thresholds.

Low-Volume Clinicians Can Opt in to MIPS

Some low-volume clinicians will be able to opt in. If you fall below one or two—but not all three—of the low-volume exclusion thresholds, you have a choice of being exempt from MIPS or electing to opt in to the program. (This option isn't available if you fall below all three thresholds.)

How do you know if you are eligible for opt-in status? Use the QPP Participation Status Tool (see "What's Your MIPS Participation Status?" at right).

How do you opt in to MIPS? Assuming that CMS offers the same opt-in procedures as it has used in previous years, you will be able to opt in for performance year 2023 by signing into your account at https://qpp.cms.gov; the window for opting in would open in January 2024, when CMS opens the submission window for performance year 2023.

What are the consequences of opting in? If you opt in for the 2023 performance year, your 2025 payments will be subject to a MIPS payment adjustment based on your 2023 MIPS final score. You also will be eligible to have your data published on Care Compare (www.medicare.gov/care-compare), which CMS set up to enable the public to see performance data on physicians who participate in Medicare. Once you have elected to opt in to MIPS for 2023, that decision is binding for that performance year.

An alternate option: Voluntary reporting. If you are excluded from MIPS, you can choose to voluntarily report. You will receive feedback reports, but—unlike those who choose to opt in—your 2025 payments won't be subject to a MIPS payment adjustment, and any quality data that you report won't be included when CMS calculates measure benchmarks. Note: If you voluntarily report, your performance information may appear on Care Compare; however, during the preview period in 2025 (see page 74), voluntary reporters can ask that their information not be publicly reported.

Small or Large Practice?

Practice size is determined by CMS based on the number of eligible clinicians in a practice:

- Small practices have 15 or fewer eligible clinicians.
- Large practices have 16 or more eligible clinicians.

CMS uses claims data to assign practice size. CMS determines how many eligible clinicians are in a practice by reviewing claims data during two 12-month time periods (see "MIPS Determination Period," previous page) and looking at the number of National Provider Identifiers (NPIs) associated with the practice's Taxpayer Identification Number (TIN). This would include NPIs of eligible clinicians who are not MIPS eligible clinicians—see "Who Does (and Doesn't) Take Part in MIPS," previous page.

Why practice size matters. CMS provides small practices with accommodations that can help them to boost their MIPS final score (see "Small Practices Get Some Breaks," page 18). For example, small practices will automatically be excluded from the promoting interoperability (PI) performance category unless they report on PI measures.

Is your practice small or large? CMS will post its practice size determinations online (see "What's Your MIPS Participation Status").

Use of TINs and NPIs as Identifiers

Taxpayer Identification Numbers (TINs) and National Provider Identifiers (NPIs) were developed by the Internal Revenue Service and CMS, respectively. A TIN is assigned to each practice for tax purposes, and NPIs are used to identify individual health care providers.

Individuals (TIN/NPI). CMS uses both your TIN and your NPI to distinguish you as a unique MIPS eligible clinician. If you have more than one TIN/NPI combination—because,

What's Your MIPS Participation Status?

Check your status. Use the QPP Participation Status Tool at https://qpp.cms.gov/participation-lookup, where you can enter your 10-digit National Provider Identifier (NPI) to find out:

- if you are eligible to participate in MIPS;
- if any exclusions apply to you (and if so, whether you can opt in to MIPS); and
- if a special status—such as being in a small or rural practice—applies to you.

MIPS tip. If you are in multiple practices, make sure you scroll down to check your status at each practice.

Preliminary eligibility information published in January. CMS uses two 12-month time segments (see "MIPS Determination Period," previous page) to assess clinicians' MIPS status. Since Jan. 1, you could use the QPP Participation Status Tool to see your preliminary eligibility information, based on data from the first time segment (Oct. 1, 2021-Sept. 30, 2022).

Final eligibility information published in November or December 2023. CMS will reconcile data from the second time segment (Oct. 1, 2022-Sept. 30, 2023) and will then update the tool with your final eligibility information. If you qualify for an exclusion based on data from one time segment, you will be exempt—even if you don't qualify for the exclusion in the other time segment.

for example, you work at multiple practices or you move to a new practice during the performance year—you will be assessed separately for each one.

Groups (TIN). If you and your colleagues decide to report as a group (see below), the group's TIN alone will—for reporting purposes—be your identifier for all four performance categories. Although groups report at the TIN level, payment adjustments will be applied at the individual TIN/NPI level. No registration is required to participate in MIPS as a group (except for a virtual group, as discussed below).

Participate as an Individual or as a Group?

You can choose to take part in MIPS as an individual or as part of a group.

What is a group? For MIPS, a group consists of two or more eligible clinicians, each with their own NPI, who have each reassigned their billing rights to the same TIN. At least one of them must be a MIPS eligible clinician.

What is group-level reporting? In group-level reporting, clinicians pool their MIPS data and are scored at the TIN level; they'll all get the same 2023 MIPS final score and will receive the same payment adjustment in 2025. There are some advantages to reporting as a group: For example, if at least 50% of clinicians in a group satisfy the requirements for a particular improvement activity, then the group as a whole scores points for that activity. But there are also some caveats to group-level reporting. For example, there are limited circumstances in which you may be excused from the promoting interoperability performance category when reporting as an individual, but you wouldn't be excused when reporting as part of a group unless all the MIPS eligible clinicians in that group were also excused from promoting interoperability. A practice that opts to report as a group will be scored as a group for all four performance categories.

What if you report as an individual *and* as part of a group? CMS will calculate two MIPS final scores for you. For the first final score, CMS will evaluate you across all performance categories based on your individual-level reporting; the second final score will be based on group-level reporting. CMS will use the higher of those two MIPS final scores to determine your payment adjustments in 2025.

How do you know if your practice can participate as a group? First, go to the QPP Participation Status Tool (see page 16). Next, enter the NPI for any clinician in the group. When the clinician's information appears, make sure that it is for performance year 2023. If the clinician is associated with more than one practice, look at the listing for your practice and check the "Group" indicator of MIPS eligibility. If there is a green checkmark next to "Group" or if there is text saying that the practice is eligible to opt in as a group, then your practice can participate in MIPS as a group.

What is a virtual group? Solo practitioners and/or groups of 10 or fewer eligible clinicians can agree to form virtual groups for the purpose of MIPS reporting, scoring, and payment adjustment. In order to join a virtual group, a solo practitioner must be a MIPS eligible clinician and a group must have no more than 10 eligible clinicians (at least one of whom must be a MIPS eligible clinician). The virtual group must include two or more TINs. There was a Dec. 31, 2022, deadline for forming a virtual group for this year.

"Extreme and Uncontrollable" Circumstances

What if extreme circumstances beyond your control limit your ability to participate in MIPS? You can apply to have your performance categories reweighted if you have difficulty reporting one or more performance categories due to "extreme and uncontrollable" circumstances. CMS hasn't set a date for when it will start reviewing applications, but last year it started in the summer. The application period will close on Dec. 31, 2023.

How performance categories are reweighted. If CMS approves your application to reweight one or more performance categories to zero, the weight(s) would be reallocated as shown in Table 3 on page 14.

What is considered extreme and uncontrollable? It must be a rare event that is entirely outside of the control of yourself and of the facility where you work. The circumstances must prevent you—either altogether or for an extended period of time—from collecting information that you need to submit for a performance category. For example, a fire that destroys the only facility where a clinician works could be considered extreme and uncontrollable, but the inability to renew a lease for that facility wouldn't. CMS will take into account the type of event, date of event, length of time over which the event took place, and other details that impact your ability to report each performance category.

During a widespread catastrophe, CMS may waive the application requirement for individuals. For example, if the Federal Emergency Management Agency declares a major disaster or public health emergency, CMS may decide to implement an automatic extreme and uncontrollable circumstances policy. This would mean that affected clinicians could have their performance categories reweighted without having to go through the application process.

CMS won't waive the application requirement for groups. This automated reweighting would only be applied to individuals; if you are reporting as part of a group, your group would have to apply for the reweighting.

How do you know whether individuals in your area are eligible for the automatic exception? CMS will post a fact sheet on the 2023 MIPS automatic extreme and uncontrollable circumstances policy, and it will list counties for which the automatic exception applies. In 2022, CMS first published this fact sheet in May and updated it each time new counties were added. You will find this fact sheet in the Resource Library at https://qpp.cms.gov.

Note: Suppose you are in a disaster zone and the end of the year is approaching, but your area hasn't yet been flagged as eligible for an automatic exemption. Consider applying for an "extreme and uncontrollable circumstances" reweighting before you miss the Dec. 31 application deadline.

***Don't* submit data to CMS on performance categories that the agency has decided to reweight.** CMS will not reweight a performance category if you report data for it.

THE RULES AREN'T ONE SIZE FITS ALL

Small Practices Get Some Breaks

While MIPS is burdensome for all MIPS eligible clinicians, it is particularly challenging for solo practitioners and small group practices. With that in mind, the MIPS rules provide small practices with some accommodations.

What Is a Small Practice?

A practice is designated as small if it has 15 or fewer eligible clinicians. Simple, right? Not quite. As described in "Small or Large Practice?" (page 16), CMS determines how many eligible clinicians are associated with your practice by reviewing claims data from two 12-month time segments (see "MIPS Determination Period," page 15).

Does CMS think your practice is small or large? You can check online using the QPP Participation Status Lookup Tool (see "What's Your MIPS Participation Status?" on page 16).

Accommodations for Small Practices

Low-volume exclusion. You may be exempt from MIPS if you provided limited Medicare Part B services—in terms of allowed charges, patients seen, or actual covered services provided—over either of two 12-month segments of the MIPS determination period (see "Exclusion 2—eligible clinicians who are below the low-volume threshold," page 15). This exclusion is most likely to benefit clinicians in small practices.

Quality—a 3-point floor for reporting a measure. If you are in a small practice, you can score 3 points for a quality measure by reporting just one patient for it via claims. (To get the 3 points reporting via the IRIS Registry, you would also need to report the data-completeness totals; see page 25.)

Quality—a 6-point small practice bonus. When CMS determines your quality score, it will add 6 points to your numerator if you are in a small practice provided that you submit data on at least one quality measure. (For more on your quality score's numerator and denominator, see "How CMS Calculates Your Quality Score," page 24.)

Quality—can report via Medicare Part B claims. Clinicians in small practices have the option of reporting quality measures via claims, and they can do so whether participating in MIPS at the individual or at the group level. (Note: If you report via Medicare Part B claims, CMS will calculate a quality score for you at the individual level. However, it will only calculate a group-level quality score if you report another performance category at the group level.)

One downside of claims-based reporting is that it is done in real time. This means that you may need to start early in the year in order to satisfy the 70%–data completeness criteria that is needed to score more than 3 achievement points for a measure.

Furthermore, many of the benchmarks for claims-based reporting have significant scoring limitations, which can make it hard to get a high achievement points total (see the benchmarks in Table 4, page 26).

An upside of reporting via claims is that you don't have to track the data-completeness totals (see page 25). This means that you can score 3 achievement points for a measure with minimal reporting. Doing that for six quality measures, along with the 6-point bonus for small practices that report quality, would give you a quality score of 40%. What would a quality score of 40% contribute to your MIPS final score? This depends on how the performance categories are weighted (see Table 3, page 14): It would contribute 12 points if the default weights apply; 16 points if promoting interoperability (PI) alone is reweighted to zero; and 20 points if both PI and cost are reweighted to zero. In conjunction with a high score for improvement activities, such quality scores could help to lower your penalty. However, you would need to report on quality more substantively in order to avoid a penalty altogether.

To learn more about claims-based reporting, visit aao.org/medicare/claims-reporting-guide.

Improvement activities—score double. Clinicians with a special status, such as being in a small practice, only have to perform one high- or two medium-weighted activities to get a 100% score for the improvement activities performance category (see "How You Will Be Scored," page 51). What would this contribute to your MIPS final score? It would contribute 15 points if the default weights apply; 15 points if cost alone is reweighted to zero; 30 points if PI alone is reweighted to zero; and 50 points if both PI and cost are reweighted to zero.

Promoting interoperability (PI) small practice exception. If you are in a small practice, you will be eligible for an automatic exception from the PI performance category (see page 49) unless you report PI data to CMS. (Note: This exception won't apply if you are reporting as part of a group and one of your colleagues reports PI data.)

DECIDE HOW YOU WILL REPORT YOUR QUALITY DATA

Pick Your Quality Collection Type(s)

For the quality performance category, your MIPS reporting options—or collection types, as CMS calls them—will depend, in part, on whether you have an EHR system. For example, the IRIS Registry offers two reporting options, one of which requires an EHR system. After reading about the options below, review Table 4 (page 26) to see which measures are available for each collection type.

Option 1: Report Quality Measures via IRIS Registry–EHR Integration

The most efficient way to report quality measures is to integrate your EHR system with the IRIS Registry. This year, for most practices, this integration process is being transitioned from FIGmd to Verana Health (see page 8).

The quality measures available to you may depend on your EHR. Dozens of quality measures are available to report via IRIS Registry–EHR integration (see Table 4, page 26), including 26 ophthalmic measures that were developed specifically for the IRIS Registry. However, you can report a measure only if the IRIS Registry is able to extract the relevant data elements from your EHR system. Thus, the quality measures that are available to you may depend on your EHR system. Furthermore, you can use integrated reporting only if your EHR system is a 2015-edition Cures Update certified EHR technology (CEHRT).

Select your quality measures. You should report at least six measures, but you can report more than that. Include an outcome measure (see page 21). The Academy urges you to include all the IRIS Registry–developed measures (see next page) that you have data for. This will increase the likelihood that CMS can establish MIPS benchmarks for those measures.

Report on all relevant patients. For each measure that you report, include both Medicare and non-Medicare patients.

Start checking your quality data. Make sure that data from your EHR system are being transferred over to the IRIS Registry correctly.

If you suspect a problem, who do you contact to make any necessary adjustments? Now that Verana Health has taken over the IRIS Registry–EHR integration process from FIGmd, you should contact your Verana Health Practice Experience Management team.

Be on the lookout for workflow problems. For example, is information being entered into the EHR correctly? Spot problems early to reduce their impact on your MIPS reporting.

Used this reporting option in 2022 but have updated your EHR or practice management system? Notify the IRIS Registry vendor no later than June 15 if there have been significant changes, such as a systems upgrade, a move to a cloud-based system, or a move to another system. If you delay, you might not be able to complete data mapping in time for 2023 MIPS reporting.

Option 2: Last Year to Report Quality Measures Manually via the IRIS Registry

Use this option if you don't use EHRs, or if you have an EHR system that isn't integrated with the IRIS Registry.

Choose from 50 quality measures. These measures (see Table 4, page 26) include 26 ophthalmology-specific measures that were developed by the IRIS Registry.

Report on all relevant patients. If you report a measure manually via the IRIS Registry, you should do so on both Medicare and non-Medicare patients.

Throughout the year, enter quality data at the individual-clinician level. It won't be until January 2024, when you get ready to hit the "submit" button that sends your data to CMS, that you indicate whether you want to report as an individual or as part of a group.

Start entering quality data ASAP. If you enter data for quality measures regularly throughout the year, you can identify areas of underperformance while you still have time to do something about it.

Track the data-completeness totals. For each measure that you report, you also need to report the total number of patients eligible for the measure and, if the measure definition includes exceptions, the total number of patients excepted. (For more on data-completeness totals, see page 25.) Contact the vendor of your billing system to see if they can provide instructions on running the appropriate reports.

2023 is the last year for manual reporting. The Academy and its IRIS Registry partner, Verana Health, will discontinue the IRIS Registry's manual web reporting tool after the 2023 performance year (see page 8).

Option 3: Report Quality Measures via Medicare Part B Claims

It will be harder to avoid a payment penalty if you report quality via claims. See Table 4 (page 26) for the seven claims-based measures that are most relevant to ophthalmology. To

explore all the claims-based measures, go to https://qpp.cms.gov/mips/explore-measures.

You must be in a small practice. Clinicians in large practices can't report via claims; clinicians in small practices can do so—and can do so whether reporting as a group or as individuals. To learn how CMS determines practice size, see "Small or Large Practice?" (page 16).

What do you report? You only report on Medicare Part B patients and—unlike manual reporting via the IRIS Registry—you don't need to report on the data-completeness totals.

When do you report? Report measures in real time using the CMS 1500 form. For detailed instructions, see aao.org/medicare/claims-reporting-guide.

Four Varieties of Measure

Here's a quick overview of MIPS clinical quality measures (MIPS CQMs), electronic CQMs (eCQMs), Medicare Part B claims-based measures, and qualified clinical data registry (QCDR) measures.

There can be more than one way to report a quality measure. Measure 226, for example, can be reported as a MIPS CQM, an eCQM, or a claims measure. For each of these three approaches, you'll need to follow a different set of measure specifications and you'll be scored against a different benchmark (see page 28).

MIPS CQMs can be reported via qualified registries and QCDRs, such as the IRIS Registry. The reporting can be done manually or sometimes electronically. Data for MIPS CQMs can be pulled from a paper chart or, in some cases, from an electronic source, such as an EHR.

eCQMs are reported electronically (e.g., via IRIS Registry–EHR integration). Measure specifications feature programming code, which helps the developers of registries and EHR systems to capture and report the requisite data. New this year: Your EHR system must have 2015-edition Cures Update certification (see page 43).

Claims-based measures can only be used by clinicians in small practices. They are reported using the CMS-1500 claims form.

QCDR measures are in a class of their own. As a QCDR, the IRIS Registry has been able to develop its own quality measures. These ophthalmology-specific measures have an "IRIS" prefix (e.g., IRIS1) and can be reported only via the IRIS Registry.

Up to 26 QCDR measures available to IRIS Registry users. You can report on any of the 26 QCDR measures manually via the IRIS Registry, but the measures available for integrated IRIS Registry–EHR reporting may depend on what data can be extracted from your EHR system. For QCDR measures, the same benchmark applies whether you are reporting it manually or electronically.

Benchmarks available for 12 QCDR measures. There are already benchmarks for IRIS2, IRIS13, IRIS17, IRIS23, IRIS43, IRIS44, IRIS46, IRIS51, IRIS53, IRIS54, IRIS55, and IRIS59.

After 2023 is over, CMS will see if there is enough 2023 performance year data to calculate benchmarks for the IRIS Registry's 14 other QCDR measures.

You Can Report via Multiple Collection Types

You can use more than one collection type for quality measures. You can, for example, report two measures via claims and four different measures via the IRIS Registry.

Using different collection types to report the same measure. But suppose you report six measures by Medicare Part B claims and you also report the *same* six measures manually via the IRIS Registry. For each measure, CMS will calculate scores for both collection types and then assign you the higher of those two scores—so your final quality score could, for example, be based on five measures that you reported via the IRIS Registry and one measure that you reported via claims.

What if you switch collection types? Suppose, for example, you report a measure via claims from January through June and then switch to reporting it manually via the IRIS Registry from July through December. CMS will not aggregate your data from both collection types. It will score you separately for each collection type.

Note: When you report via more than one collection type, you must use the same identifier each time (see "Use of TINs and NPIs as Identifiers," page 16).

Other Reporting Options

Via your EHR vendor. Some EHR vendors may offer a reporting option, but they won't include the QCDR measures (because these are available only through the IRIS Registry).

Consider reporting quality at the group level. There are some advantages to reporting as a group. Suppose, for example, a practice consists of four cataract subspecialists and a pediatric ophthalmologist. The latter might find it a challenge to report on six quality measures, but doing so wouldn't be a problem for the group as a whole.

If you're in an accountable care organization (ACO), you should still report MIPS quality measures in case your ACO's reporting is unsuccessful. If the ACO is successful in its MIPS reporting, CMS can ignore the quality measures that you reported. But if your ACO is unsuccessful in its MIPS reporting, your independent quality reporting can safeguard you from the –9% payment adjustment in 2025.

Facility-based scoring isn't an option for most ophthalmologists. Facility-based scoring will be available to you only if you provide at least 75% of your covered professional services at an inpatient hospital (place of service [POS] code: 21), an on-campus outpatient hospital (POS code: 22), or an emergency room (POS code: 23), with at least one service at an inpatient hospital or emergency room. This is based on claims submitted between Oct. 1, 2021, and Sept. 30, 2022.

What if you are eligible for facility-based scoring but you also do your own MIPS reporting? CMS will assign you the facility's score for quality and cost unless your separate MIPS submission earns you a higher combined score for those two performance categories.

WATCH OUT FOR MEASURES THAT HAVE SCORING LIMITATIONS

How to Report Quality Measures

Your quality score can make or break your MIPS performance. Under its default weighting, quality contributes up to 30 points to your MIPS final score. Start by deciding which quality measures you will report, make sure that you understand the specifications for those measures, and keep track of your measure performance rates throughout the year.

Reporting Quality Measures

Report at least one outcome measure. A measure that is listed as an intermediate outcome measure or a patient-reported outcome measure would count for this purpose.

If no outcome measure is available, you must report another high-priority measure instead. Alternative high-priority quality measures include appropriate use, care coordination, efficiency, health equity, patient experience, patient safety, and opioid-related measures.

Report at least six quality measures (including the one mentioned above). Your quality score will be based on your achievement points for up to six quality measures, plus your quality improvement percent score (see page 24).

Table 4 (page 26) shows the MIPS clinical quality measures (MIPS CQMs), electronic CQMs, and Qualified Clinical Data Registry (QCDR) measures that you can report via the IRIS Registry. You can report MIPS CQMs and QCDR measures manually via the IRIS Registry. You can report eCQMs, QCDR measures, and some MIPS CQMs via IRIS Registry–EHR integration, but only if the IRIS Registry is able to extract the relevant data from your EHR.

Quality 101

Default weight in MIPS final score: 30%.
Performance period: Full calendar year.
Reporting requirements: Aim to report on at least six quality measures. At least one of the six measures must be an outcome measure (or, if no outcome measure is available to you, another type of high priority measure).
Collection types: You can report via IRIS Registry–EHR integration, manually via the IRIS Registry, and/or via your EHR vendor. Small practices—but not large practices—can report via Medicare Part B claims.

Table 4 also shows the seven claims-based measures that are most relevant to ophthalmology, but there are many more. (Explore them all at https://qpp.cms.gov/mips/explore-measures; make sure you select "2023" as the performance year and "Medicare Part B claims measures" as the collection type.)

What if you report on more than six quality measures? If you report on seven or more measures, CMS will determine which six of those measures will give you the highest number of measure achievement points based on your performance rates, with the caveat that one of them must be an outcome measure (or another type of high priority measure, if no outcome measure is available to you).

If you report manually via the IRIS Registry, you need additional data on patient counts. When you report a quality measure manually via a QCDR, such as the IRIS Registry, you must include 1) the number of patients eligible for that measure and 2) for measures that include exceptions, the number of patients for whom the exception applies (see page 25).

Report more than six quality measures to give yourself a margin of error. In case you run into a problem with one of your quality measures, you can hedge your bets by reporting more than six measures. Suppose, for example, you are reporting a measure that doesn't yet have a benchmark. If CMS can't calculate a benchmark for that measure after the performance year is over, your scoring will be restricted (see "What If There Is No Benchmark?" on page 23).

Meet Quality's Data Submission Thresholds

When you report a measure, you must meet both the case minimum requirement and the data completeness criteria in order to earn achievement points based on your performance rate (see next page).

The case minimum: Report on at least 20 patients. You will actively report six or more quality measures. For reportable measures, the case minimum is typically 20—though CMS has the authority to introduce new measures that might have a case minimum other than 20. (Note: The case minimum for administrative claims–based measures tends to be much higher. For example, see "The HWR Measure for Large Practices," page 23, which has a case minimum of 200.)

The data completeness criteria: Report on at least 70% of denominator-eligible patients. For each measure that you report, submit data on at least 70% of denominator-

eligible patients who were seen during the entire 2023 calendar year. (Note: CMS has announced that the data completeness criteria will be raised to 75% next year.)

Who are the denominator-eligible patients? That depends on the quality measure as well as on what collection type you are using to report that measure. Suppose, for example, you are reporting measure 1: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). The denominator-eligible patients for that measure would be those with diabetes who are 18-75 years old. If you are reporting via the Medicare Part B claims collection type, you include only Medicare patients; for any other collection type, you also include non-Medicare patients. (Where can you find the denominator criteria for quality measures? When you are logged in to the IRIS Registry, you can download PDFs of each quality measure. You also can download measure specifications as part of the *2023 IRIS Registry Preparation Kit*.)

What if you don't meet the case minimum requirement for a reported measure? If you are in a large practice, you score 0 points; if you are in a small practice you score 3 points provided you report on at least one patient. New measure exception: If the measure is in its first or second year of MIPS, you would score 7 or 5 points respectively, provided you meet the 70%–data completeness criteria and, if reporting manually via the IRIS registry, report the data-completeness totals (see page 25).

What if you don't satisfy the 70%–data completeness criteria for a reported measure? If you are in a large practice, you score 0 points; if in a small practice, you score 3 achievement points provided that you report on at least one patient and, if reporting manually via the IRIS Registry, the data-completeness totals (see page 25).

Do Not Cherry-Pick Your Patients

If you report on fewer than 100% of patients, do not cherry-pick. CMS has warned that if you report on a measure for fewer than 100% of applicable patients, you must not cherry-pick patients with the goal of boosting your performance rate. The MIPS regulations address this when they state that if "quality data are submitted selectively such that the submitted data are unrepresentative of a MIPS eligible clinician or group's performance, any such data would not be true, accurate, or complete." In an audit, you'd be failed.

Your Performance Rate Will Be Scored Against a Benchmark

Did you report enough data for a measure? When you report a quality measure, CMS first determines whether you met the case minimum requirement (at least 20 patients) and the data completeness criteria (at least 70% of applicable patients). If you did, CMS will see how your performance rate stacks up against the measure's benchmark.

Benchmarks are typically based on historical performance data. CMS used 2021 performance data to try to establish 2023 benchmarks for quality measures.

Up to three different benchmarks. Quality measures can have different measure specifications—and different benchmarks—for different collection types (see "Four Varieties of Measure," page 20). For some measures, different benchmarks apply depending on whether you are reporting it 1) as a claims-based measure, 2) as a MIPS CQM (which typically involves reporting it manually via the IRIS Registry), or 3) as an eCQM (whether via IRIS Registry–EHR integration or via your EHR vendor).

However, some measures can't be reported by all collection types and therefore have fewer than three benchmarks. For example, measure 374: Closing the Referral Loop can't be reported via claims. And the IRIS Registry's QCDR measures (e.g., IRIS2: Glaucoma: IOP Reduction) have the

ICD-10 Turbulence and Changes in Clinical Guidelines

During the course of the year, a quality measure may be impacted by "significant changes" to its clinical guidelines, to its measure specifications, or to relevant codes (e.g., updates or deletions of ICD-10, CPT, or HCPCS codes). This can mean that continued adherence to the measure's original specifications—as defined at the start of the performance year—could result in "patient harm" and/or "misleading results" on performance quality. In such cases, CMS may truncate the performance period for that measure or suppress the measure altogether, depending on when in the year the changes take place.

Truncation or suppression? If a quality measure has been impacted by a significant change, are there nine consecutive months of performance data that are unaffected by that change? If so, CMS will assess clinician performance for that measure based on a truncated nine-month performance period. If not, CMS will suppress the measure altogether.

Truncation example. Each year, on Oct. 1, CMS implements changes to the ICD-10 codes. These diagnosis codes are used to determine which patients are eligible for each quality measure. If the Oct. 1 changes to the ICD-10 code set have significant repercussions for a measure's performance rate, CMS can score you on that measure based on your performance from Jan. 1 to Sept. 30.

What if a measure is suppressed? Clinicians aren't scored on suppressed quality measures. If you submitted data on a quality measure before it was suppressed—because, for example, you reported it by claims—1) you wouldn't score points for that measure, and 2) when CMS calculates your quality score, it would reduce your denominator by 10 points (so you wouldn't be penalized for reporting the suppressed measure).

Which quality measures are affected? CMS will announce on its website which measures are scored on a truncated performance period or suppressed altogether, and the agency has said that it will do so "as soon as technically feasible."

same benchmark regardless of whether you are reporting via manual entry or via IRIS Registry–EHR integration.

Your achievement score for a measure will depend on how your performance rate stacks up against the measure's benchmark. Each benchmark is broken into deciles. Assuming no scoring limitations apply (see below), if your performance rate falls within:

- deciles 1 or 2, you score 3 achievement points if you are in a small practice; if in a large practice, your score will depend on where you fall within the decile (e.g., if you fall in the first decile, you can earn between 1.0 and 1.9 achievement points)
- deciles 3 through 9, your score will depend on where you fall within that decile (e.g., if you fall in the third decile, you can earn between 3.0 and 3.9 achievement points)
- decile 10, you score 10 achievement points.

Note: new measures in their first or second year have a floor of 7 or 5 points, respectively. To review benchmarks for the quality measures that are most relevant to ophthalmology, see Table 4 (page 26).

Some Benchmarks Are Subject to Scoring Limitations

Scoring "stalls" for some benchmarks due to high performance rates. The scoring for some benchmarks approaches maximum performance before the ninth decile. If, for example, you use the IRIS Registry to manually report measure 128: Body Mass Index (BMI) Screening, the relevant benchmark reaches a 99.99% performance rate at the seventh decile (see page 26 for the measure's benchmark in full). You can still earn 10 achievement points with a 100% performance rate, but if you have less-than-perfect performance, scoring stalls at 7.9 achievement points.

A 7-point cap for some benchmarks. Once a quality benchmark is in its second year of being "topped out" it becomes subject to a 7-point cap.

What is a topped-out benchmark? CMS considers a benchmark to be topped out if there is limited opportunity for improvement. For example, a process-based measure is considered topped out if the median performance rate was at least 95%. CMS is concerned that such benchmarks provide very little room for improvement for most of the MIPS eligible clinicians who use those measures. Once a benchmark is topped out for three consecutive performance years, CMS will consider eliminating it in the fourth year. Furthermore, if a benchmark is extremely topped out (e.g., average performance rate of a process-based measure is 98% or higher), it may eliminate it the following year.

What If There Is No Benchmark?

If there were not enough performance data from 2021 to establish a reliable benchmark for a measure, or if the measure didn't exist in its current form in 2021, CMS will try to establish a benchmark retroactively using 2023 performance data.

However, CMS won't assign a benchmark to a measure unless at least 20 clinicians or groups submit performance data that meet the two data submission thresholds. If CMS is unable to establish a benchmark for a measure, scoring depends on whether it is a new measure in its first or second year or if it is a more established measure.

For measures in their first or second year of MIPS, a 7- or 5-point floor, respectively. Provided that you meet the 70%–data completeness criteria and, if applicable, report the data-completeness totals (see page 25), you will earn a minimum of 7 points for a measure in its first year and a minimum of 5 points for a measure in its second year. For example, the 7-point floor would apply to measure 487: Screening for Social Drivers of Health, which was added to MIPS this year.

For more established measures, 3 or 0 points for small and large practices, respectively. If CMS is unable to establish a benchmark for a measure, small practices can get 3 achievement points for reporting that measure and—new this year—large practices will get 0 achievement points for reporting it.

Some Benchmarks Are "Flat"

CMS has applied flat benchmarks to these two measures:

- Measure 1: Diabetes: Hemoglobin A1c (HBA1c) Poor Control (>9%). Measure 1 has a flat benchmark when reported as a MIPS CQM.
- Measure 236: Controlling High Blood Pressure. Measure 236 has a flat benchmark when reported as a claims measure or a MIPS CQM, but not when reported as an eCQM.

What is a flat benchmark? Most benchmarks are based on historic performance rates. By contrast, flat benchmarks are based on a simple formula. Scoring will depend on whether or not you are reporting an inverse measure. For inverse measures, such as measure 1: Diabetes: Hemoglobin A1c Poor Control (>9%), a lower performance rate will earn you a higher score.

When an inverse measure has a flat benchmark, a performance rate of 10% or less earns you 10 achievement points; a performance rate of 10.01%-20% earns you 9 achievement points, etc. (For example, see measure 1's benchmark on page 26.)

For a flat benchmark that isn't an inverse measure, a performance rate of at least 90% earns you 10 achievement points; a performance rate of 80%-89.9% earns you 9 achievement points, etc. (For example, see page 28 for measure 236's benchmarks when reported manually or via claims.)

The HWR Measure for Large Practices

It is very unlikely that you will be scored on quality measure 479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Eligible Clinician Groups. This measure only applies to large groups (16 or more eligible clinicians) that meet the case minimum requirement of 200 cases involving patients who are at least 65 years old. Practices don't report this measure; they are evaluated based on Medicare administrative claims data.

Why did CMS introduce flat benchmarks? CMS was concerned that using the standard performance-based benchmarks for measures 1 and 236 may have motivated clinicians to reduce blood sugar or blood pressure to levels that might be too low for patients with certain medical conditions.

You Can Earn an Improvement Percent Score

If you score more achievement points for quality measures in 2023 than you did in 2022, you may be able to earn a quality improvement percent score.

CMS checks whether your score for measure performance has improved. CMS compares your 2023 performance with your 2022 performance to determine your improvement percent score. For each of the two years, it assigns you a quality performance category achievement percent score, which it calculates by dividing your total measure achievement points by your total available measure achievement points. (Note: When making its calculation, CMS sets a floor of 30% for your 2022 quality performance.)

How CMS determines your improvement percent score. Your improvement percent score = ([your increase in quality performance category achievement percent score from 2022 to 2023] ÷ your 2022 quality performance category achievement percent score) × 10.

The improvement percent score is capped at 10%. If you doubled your measure achievement points, you would get the maximum score of 10%.

You can't get a negative score. If your performance stayed the same or declined, your improvement percent score would be 0%.

How CMS Calculates Your Quality Score

This can be described as a four-step process.

1. CMS calculates your achievement points total: CMS determines your total measure achievement points, which is the sum of your achievement points for up to six quality measures that you reported plus—if applicable—your score for the HWR measure (see "The HWR Measure for Large Practices," previous page).

2. CMS determines your numerator: CMS calculates your numerator, which is your total measure achievement points plus—if you are in a small practice that submits data on at least one quality measure—a 6-point small practice bonus.

3. CMS determines your denominator: CMS calculates your denominator, also known as your total available measure achievement points, which—assuming that you had at least six quality measures available to report—is 60 (or 70 if the HWR measure also applies). In limited circumstances, CMS may determine that you have fewer than six quality measures to report and can reduce that denominator accordingly. If, for example, you report a measure that has been suppressed (see page 22), CMS would reduce your denominator by 10.

4. CMS does the math: CMS divides your numerator by your denominator, turns the resulting fraction into a percentage, and then adds your improvement percent score. The resulting percentage is your quality performance category percent score, which is capped at 100%. Unless your performance categories are reweighted (see "Table 3: How the Performance Categories Are Weighted," page 14), it contributes up to 30 points to your MIPS final score. For example, if your quality score is 60%, it would contribute 18 points (60% of 30 points).

Which Quality Measures Should You Report?

See what measures you should be focusing on. Skim Table 4 on page 26. Look for measures where you are most likely to 1) satisfy the case minimum of 20 patients, 2) satisfy the 70%–data completeness criteria, and 3) achieve a high performance rate. Don't assume that the measures you reported for 2022 will be your best options in 2023. Look for new measures with a 7-point floor, but also be mindful of measures that have scoring limitations—such as score-stalling or a 7-point cap—or that don't yet have a benchmark.

Understand the measure specifications. Familiarize yourself with the measures that you expect to be scored on and make sure that you are performing and documenting them in line with their current specifications. If you report via the IRIS Registry, you can access detailed measure specifications via your dashboard. You can also download measure specifications as part of the *2023 IRIS Registry Preparation Kit,* which is available at aao.org/iris-registry/user-guide/getting-started. Note: A measure can have different sets of specifications for different collection types.

Reporting quality via IRIS Registry–EHR integration? Check your measures monthly (or at least quarterly) to look for potential problems in data mapping or workflow. You need to make requests for mapping refinements no later than Oct. 31. If you make changes to your practice management system or your EHR system (such as an upgrade or a change to your network server), notify the IRIS Registry vendor by June 15.

Reporting quality manually via the IRIS Registry? Have you entered your quality measure data from January, February, and March into the IRIS Registry? If not, it's advisable to start catching up. Although your data entry into the IRIS Registry doesn't have to be done in real time, you should not leave it until the end of the year. Keep in mind that you will need to keep track of your data-completeness totals (see next page).

Reporting quality via Medicare Part B claims? If you plan to meet the 70% data completeness criteria for a measure, remember that you need to report throughout the year in real time.

Ask the practice's clinicians to review their performance rates. Throughout the year, give each care provider his or her own IRIS Registry report. Encourage them to review their performance rates across the quality measures.

SEE IF YOU CAN GET THIS DATA FROM YOUR BILLING SYSTEM

IRIS Registry: Manual Reporters Will Need Their Data-Completeness Totals

Since 2018, CMS has required practices that report quality measures manually through registries to submit data-completeness totals for each quality measure reported. (Note: This is different from the 70%–data completeness criteria described on page 21.)

What data-completeness total(s) must you submit for each quality measure? For each quality measure that you report manually via the IRIS Registry, do the following:

- Report the total number of patients seen during the year (from all payers) who were eligible for the measure.
- If the measure includes an exception, report the total number of patients excepted from the measure.

If you are reporting manually via the IRIS Registry, you won't be able to submit a measure's quality data to CMS without including the total number of eligible patients and, if applicable, the total number of excepted patients.

Contact the vendor of your billing system. Many practices will be able to readily collect the eligible patient totals from their billing systems. Contact your billing system vendor and ask for instructions on how to run the appropriate reports.

Find out which patients would be eligible for each of your quality measures. At the IRIS Registry dashboard, you can view detailed measure specifications of each quality measure that you plan to report. The detailed measure descriptions include the denominator criteria that indicate which patients qualify for each measure.

Report the Eligible Totals

Get the total number of eligible patients for quality measures. After determining the denominator criteria, use your billing system to run a report of patients who meet those criteria. This will give you the total number of patients eligible for the measure. (Note: Run these reports after the end of the calendar year.)

Example: Determining the total number of eligible patients for Measure 14: AMD: Dilated Macular Examination. According to the measure's specifications, eligible patients are those with AMD who are at least 50 years old. Run a report in your billing system for the date range "1/1/23-12/31/23." Apply a filter for the following:

- Diagnosis of AMD (using ICD-10 codes outlined in the measure specification)
- Eligible CPT codes billed during the 2023 calendar year (using CPT codes outlined in the measure specifications, but excluding any that have certain telehealth modifiers appended or have "12" as the Place of Service.)
- Date of birth, so that only patients age 50 years and older are included. If your system doesn't have this functionality, you can print out the report using the diagnosis- and CPT code–criteria and then remove patients who do not meet the measure's age criteria.

Report the Exceptions

Get the total number of patient exceptions for a quality measure. Some quality measures have exceptions. These are often medical- or patient-related. For example, there may be a medical reason why you can't perform a dilated macular exam. Such exceptions should be supported by documentation. It may be difficult to run a report in your billing system to produce this total, and it may require manual counting.

Some quality measures do not have exceptions. Of the quality measures that can be manually reported via the IRIS Registry, the following do not have exceptions: Measures 1, 117, 141, 191, 236, 238, 374, 384, 385, 389, 402, and 487, and the manually reported measures developed by the IRIS Registry (IRIS1, IRIS2, etc.).

Can't Get These Totals Electronically?

Some practices collect data manually by adding a MIPS worksheet to the patient charts. If you are not able to use your billing system to collect the number of patients eligible for a quality measure and/or the number excepted from the measure, you can use a manual approach for gathering this information. For example, some practices set up a manual system at the start of the year: They create a quality measure worksheet that they place in every patient's chart. This worksheet asks for all the information that is needed for the measures that the practice plans to report, and staff are trained to fill it out at each patient visit. This data can be used to calculate the eligible patients and exceptions.

Some practices keep up with their MIPS data entry throughout the year. Some practices manually enter 100% of eligible patients into the IRIS Registry throughout the year on a daily, weekly, or monthly basis. Both the eligible totals and the patient exception totals will be captured during that reporting, and the practice will have them on hand in early 2024 when it is time to submit its quality data to CMS.

Table 4: Quality Measures Benchmarks

eCQMs, MIPS CQMs, and claims-based measures. eCQMs can be reported via IRIS Registry–EHR integration; MIPS CQMs can be reported manually via the IRIS Registry and, in some cases, via IRIS Registry–EHR integration; claims-based measures can only be reported by small practices.

Report an outcome measure. You must report at least one outcome or intermediate outcome measure—look for measures that are flagged as "Outcome" or "Interm. outcome" in the "High Priority" column below. If none are available to you, report at least one other type of high-priority measure ("Other HP") instead.

Meet two data submission thresholds. If your reporting for a quality measure satisfies both the case minimum requirement (20 patients) and the data completeness criteria (70% of denominator-eligible patients), your performance rate will be compared against a benchmark (if there is one), and you can earn the achievement points indicated below. If you are manually reporting via the IRIS Registry, you also must track your data completeness totals (see page 25). If you meet those reporting requirements, the "Points" column shows the range of points available to you for each measure. Some measures are subject to a 7-point

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PREVENTIVE MEASURES								
Interm. outcome	**1: Diabetes: Hemoglobin A1c Poor Control (>9%)**	MIPS CQM	1*-10	**Performance rate**	99.00%-90.01%	90.00%-80.01%	80.00%-70.01%	
				Points	1	2	3	
		Claims	No benchmark					
		eCQM	1*-10	**Performance rate**	99.52%-93.34%	93.33%-75.01%	75.00%-57.61%	
				Points	1	2	3	
	117: Diabetes: Eye Exam	MIPS CQM	1*-5.9 or 7	**Performance rate**	1.30%-48.28%	48.29%-95.67%	95.68%-99.03%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	0.59%-5.89%	5.90%-13.81%	13.82%-22.99%	
					1.0-1.9	2.0-2.9	3.0-3.9	
	128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	MIPS CQM	1*-7.9 or 10	**Performance rate**	2.28%-31.81%	31.82%-64.93%	64.94%-85.32%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3-4.9 or 7	**Performance rate**			95.78%-99.25%	
				Points			3.0-3.9	
		eCQM	No benchmark					
Other HP	**130: Documentation of Current Medications in the Medical Record**	MIPS CQM	3-7 points	**Performance rate**	2.60%-30.28%	30.29%-87.25%	87.26%-95.56%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	

cap and/or "score stalling" (see page 23).

Understand the measures. Detailed measure specifications can be downloaded via the IRIS Registry dashboard. Those specifications are also available as part of the *2023 IRIS Registry Preparation Kit,* which is availabe at aao.org/iris-registry/user-guide/getting-started.

Some changes to this list of measures. If you used this table to plan your quality measure reporting in 2022, you may notice some changes this year. Measures 110 and 110 have been replaced with measure 493; measures 440 and 487 have been added; measure 265 has been removed; and measures 117 and 130 are no longer available for claims-based reporting.

New for 2023: 3-point floor applies to small practices, but not large practices. In the chart below, the scoring for deciles 1 and 2 only applies to large practices. Small practices that meet the 70%–data completeness criteria and, if applicable, report data-completeness totals will score a minimum of 3 points.

Important caveat. If reporting via IRIS Registry–EHR integration, you can only report a measure if the relevant data elements are available for extraction from your EHR system. Check with staff from Verana Health to work on mapping for any of these measures.

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PREVENTIVE MEASURES							
70.00%-60.01%	60.00%-50.01%	50.00%-40.01%	40.00%-30.01%	30.00%-20.01%	20.00%-10.01%	≤10.00%	Flat benchmark, inverse measure
4	5	6	7	8	9	10	
Because this measure was suppressed as an eCQM in 2021, CMS wasn't able to create a benchmark. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							Inverse measure
57.60%-46.16%	46.15%-38.18%	38.17%-32.27%	32.26%-27.33%	27.32%-22.51%	22.50%-17.08%	≤17.07%	Inverse measure
4	5	6	7	8	9	10	
99.04%-99.73%	99.74%-99.99%					100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9					7.0	
23.00%-33.25%	33.26%-46.03%	46.04%-80.50%	80.51%-97.64%	97.65%-99.20%	99.21%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
85.33%-94.61%	94.62%-98.34%	98.35%-99.71%	99.72%-99.99%			100%	Topped out
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9			10.0	
99.26%-99.99%						100%	Topped out, 7-point cap
4.0-4.9						7.0	
Because this measure was suppressed as an eCQM in 2021, CMS wasn't able to create a benchmark. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
95.57%-98.61%	98.62%-99.73%	99.74%-99.98%	99.99%			100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9	7.0			7.0	

Continued on page 28.

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PREVENTIVE MEASURES								
Other HP	**130: Documentation of Current Medications in the Medical Record** (continued)	eCQM	1*-7	**Performance rate**	7.66%-66.24%	66.25%-83.07%	83.08%-89.81%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	MIPS CQM	1*-8.9 or 10	**Performance rate**	2.88%-17.29%	17.30%-34.61%	34.62%-53.73%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3-4.9 or 10	**Performance rate**			90.20%-96.42%	
				Points			3.0-3.9	
		eCQM	1*-10	**Performance rate**	2.05%-13.94%	13.95%-24.99%	25.00%-36.10%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Interm. outcome	**236: Controlling High Blood Pressure**	MIPS CQM	1*-10	**Performance rate**	1.00%-9.99%	10.00%-19.99%	20.00%-29.99%	
				Points	1	2	3	
		Claims	3-10	**Performance rate**			20.00%-29.99%	
				Points			3	
		eCQM	1*-10	**Performance rate**	2.74%-41.95%	41.96%-51.35%	51.36%-56.60%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**238: Use of High-Risk Medications in Older Adults**	MIPS CQM	1*-4.9 or 10	**Performance rate**	20.00%-3.74%	3.73%-0.64%	0.63%-0.06%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-7.9 or 10	**Performance rate**	21.82%-10.56%	10.55%-6.71%	6.70%-3.85%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	MIPS CQM	1*-10	**Performance rate**	0.05%-12.03%	12.04%-21.48%	21.49%-28.32%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3-6.9 or 10	**Performance rate**			84.62%-96.65%	
				Points			3.0-3.9	

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PREVENTIVE MEASURES							
89.82%-93.62%	93.63%-96.11%	96.12%-97.74%	97.75%-98.78%	98.79%-99.46%	99.47%-99.86%	≥99.87%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9	7.0	7.0	7.0	7.0	
53.74%-71.99%	72.00%-84.84%	84.85%-92.85%	92.86%-97.77%	97.78%-99.99%		100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
96.43%-99.99%						100%	Topped out
4.0-4.9						10.0	
36.11%-47.99%	48.00%-60.35%	60.36%-72.49%	72.50%-83.99%	84.00%-92.30%	92.31%-98.32%	≥98.33%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
30.00%-39.99%	40.00%-49.99%	50.00%-59.99%	60.00%-69.99%	70.00%-79.99%	80.00%-89.99%	≥90.00%	Flat benchmark
4	5	6	7	8	9	10	
30.00%-39.99%	40.00%-49.99%	50.00%-59.99%	60.00%-69.99%	70.00%-79.99%	80.00%-89.99%	≥90.00%	Flat benchmark
4	5	6	7	8	9	10	
56.61%-60.70%	60.71%-64.23%	64.24%-67.54%	67.55%-71.09%	71.10%-75.27%	75.28%-81.34%	>= 81.35%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
0.05%-0.01%						0%	Inverse measure, topped out
4.0-4.9						10.0	
3.84%-1.80%	1.79%-0.65%	0.64%-0.17%	0.16%-0.01%			0%	Inverse measure, topped out
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9			10.0	
28.33%-35.86%	35.87%-50.24%	50.25%-71.52%	71.53%-91.75%	91.76%-98.68%	98.69%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
96.66%-99.03%	99.04%-99.72%	99.73%-99.99%				100%	Topped out
4.0-4.9	5.0-5.9	6.0-6.9				10.0	

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
PREVENTIVE MEASURES								
Other HP	**318: Falls: Screening for Future Fall Risk**	eCQM	1*-10	**Performance rate**	0.14%-3.90%	3.91%-16.79%	16.80%-35.69%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**374: Closing the Referral Loop: Receipt of Specialist Report**	MIPS CQM	1*-5.9 or 7	**Performance rate**	0.90%-30.42%	30.43%-66.93%	66.94%-84.37%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	0.50%-4.84%	4.85%-11.35%	11.36%-17.30%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	402: Tobacco Use and Help with Quitting Among Adolescents	MIPS CQM	1*-7	**Performance rate**	37.84%-84.08%	84.09%-92.40%	92.41%-96.66%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
	493: Adult Immunization Status	MIPS CQM	No benchmark					
HEALTH EQUITY								
Other HP	**487: Screening for Social Drivers of Health**	MIPS CQM	No benchmark					
CATARACT/ANTERIOR SEGMENT								
Outcome	**191: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**	MIPS CQM	1*-6.9 or 10	**Performance rate**	23.55%-85.70%	85.71%-92.90%	92.91%-97.02%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	17.24%-74.47%	74.48%-88.07%	88.08%-92.66%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**389: Cataract Surgery: Difference Between Planned and Final Refraction**	MIPS CQM	1*-8.9 or 10	**Performance rate**	1.35%-14.82%	14.83%-24.10%	24.11%-33.07%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS54: Complications After Cataract Surgery**	QCDR	1*-8.9 or 10	**Performance rate**	7.50%-3.67%	3.66%-2.48%	2.47%-1.91%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS59: Regaining Vision After Cataract Surgery**	QCDR	1*-10	**Performance rate**	1.37%-16.32%	16.33%-23.66%	23.67%-28.31%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
For two additional measures, see IRIS55 and IRIS60, under "Glaucoma"								

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PREVENTIVE MEASURES							
35.70%-52.46%	52.47%-66.86%	66.87%-79.38%	79.39%-88.68%	88.69%-95.36%	95.37%-98.91%	≥98.92%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
84.38%-95.11%	95.12%-99.99%					100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9					7.0	
17.31%-23.47%	23.48%-30.49%	30.50%-38.82%	38.83%-50.50%	50.51%-66.56%	66.57%-85.70%	≥ 85.71%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
96.67%-98.71%	98.72%-99.64%	99.65%-99.99%				100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9				7.0	
New measure incentive: If you meet the data completeness criteria and, if applicable, report data-completeness totals, you'll score a minimum of 7 points. And if CMS can create a benchmark based on 2023 performance data, you may be able to score more than 7 points.							New measure, 7-point floor
HEALTH EQUITY							
New measure incentive: If you meet the data completeness criteria and, if applicable, report data-completeness totals, you'll score a minimum of 7 points. And if CMS can create a benchmark based on 2023 performance data, you may be able to score more than 7 points.							New measure, 7-point floor
CATARACT/ANTERIOR SEGMENT							
97.03%-98.35%	98.36%-99.17%	99.18%-99.99%				100%	
4.0-4.9	5.0-5.9	6.0-6.9				10.0	
92.67%-95.13%	95.14%-96.76%	96.77%-97.85%	97.86%-98.62%	98.63%-99.26%	99.27%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
33.08%-45.00%	45.01%-64.66%	64.67%-91.12%	91.13%-97.99%	98.00%-99.99%		100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
1.90%-1.67%	1.66%-1.26%	1.25%-0.87%	0.86%-0.44%	0.43%-0.01%		0%	Inverse measure
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
28.32%-32.17%	32.18%-35.62%	35.63%-42.78%	42.79%-49.30%	49.31%-56.74%	56.75%-67.34%	≥67.35%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
CORNEA/EXTERNAL DISEASE								
Outcome	**IRIS1: Endothelial Keratoplasty: Postoperative Improvement in BCVA to 20/40 or Better**	QCDR	No benchmark					
Outcome	**IRIS38: Endothelial Keratoplasty: Dislocation Requiring Surgical Intervention**	QCDR	No benchmark					
GLAUCOMA								
	12: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	eCQM	1*-10	**Performance rate**	3.88%-68.61%	68.62%-83.12%	83.13%-88.68%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care**	MIPS CQM	1*-8.9 or 10	**Performance rate**	1.39%-52.26%	52.27%-75.16%	75.17%-86.30%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		Claims	3 or 10	**Performance rate**				
				Points				
Interm. outcome	**IRIS2: Glaucoma: Intraocular Pressure (IOP) Reduction**	QCDR	1*-10	**Performance rate**	1.80%-50.92%	50.93%-61.69%	61.70%-66.90%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS39: IOP Reduction Following Trabeculectomy or an Aqueous Shunt Procedure**	QCDR	No benchmark					
Outcome	**IRIS43: IOP Reduction Following Laser Trabeculoplasty**	QCDR	1*-10	**Performance rate**	5.00%-8.69%	8.70%-14.28%	14.29%-17.41%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS44: Visual Field Progression in Glaucoma**	QCDR	1*-10	**Performance rate**	90.00%-18.19%	18.18%-13.34%	13.33%-12.65%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS55: VA Improvement Following Cataract Surgery and Minimally Invasive Glaucoma Surgery**	QCDR	1*-10	**Performance rate**	3.70%-8.26%	8.27%-27.26%	27.27%-33.32%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS60: VA Improvement Following Cataract Surgery Combined with a Trabeculectomy or an Aqueous Shunt Procedure**	QCDR	No benchmark					

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
CORNEA/EXTERNAL DISEASE							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							Inverse measure
GLAUCOMA							
88.69%-91.93%	91.94%-94.16%	94.17%-96.07%	96.08%-97.65%	97.66%-98.95%	98.96%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
86.31%-93.40%	93.41%-96.25%	96.26%-98.25%	98.26%-99.37%	99.38%-99.99%		100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9		10.0	
						100%	
						10.0	
66.91%-71.08%	71.09%-74.28%	74.29%-77.60%	77.61%-80.12%	80.13%-83.49%	83.50%-87.58%	≥87.59%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
17.42%-21.61%	21.62%-24.34%	24.35%-31.66%	31.67%-36.16%	36.17%-77.58%	77.59%-93.32%	≥93.33%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
12.64%-11.64%	11.63%-11.14%	11.13%-7.15%	7.14%-5.01%	5.00%-4.06%	4.05%-1.40%	≤1.39%	Inverse measure
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
33.33%-33.69%	33.70%-36.72%	36.73%-43.89%	43.90%-46.86%	46.87%-48.88%	48.89%-65.84%	≥65.85%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
NEURO-OPHTHALMOLOGY								
Other HP	**419: Overuse of Imaging for the Evaluation of Primary Headache**	MIPS CQM	1*-7.9 or 10	**Performance rate**	68.04%-37.83%	37.82%-16.49%	16.48%-8.87%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS56: Adult Diplopia: Improvement of Ocular Deviation or Absence of Diplopia or Functional Improvement**	QCDR	No benchmark					
Outcome	**IRIS57: Idiopathic Intracranial Hypertension: Improvement of Mean Deviation or Stability of Mean Deviation**	QCDR	No benchmark					
OCULOFACIAL PLASTICS/RECONSTRUCTIVE								
Other HP	**137: Melanoma: Continuity of Care—Recall System**	MIPS CQM	1*-2.9* or 10	**Performance rate**	15.56%-92.15%	92.16%-99.99%		
				Points	1.0-1.9	2.0-2.9		
Other HP	**138: Melanoma: Coordination of Care**	MIPS CQM	1*-3.9 or 7	**Performance rate**	3.33%-60.77%	60.78%-93.01%	93.02%-99.99%	
					1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**397: Melanoma Reporting**	MIPS CQM	1*-1.9* or 7	**Performance rate**	41.33 - 99.99			
				Points	1.0-1.9			
		Claims	3-3.9 or 7	**Performance rate**			98.44%-99.99%	
							3.0-3.9	
Other HP	**440: Skin Cancer: Biopsy Reporting Time—Pathologist to Clinician**	MIPS CQM	1*-4.9 or 7	**Performance rate**	71.05%-96.73%	96.74%-98.98%	98.99%-99.73%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS6: Acquired Involutional Entropion: Normalized Lid Position After Surgical Repair**	QCDR	No benchmark					
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS								
Outcome	**IRIS48: Adult Surgical Esotropia: Postoperative Alignment**	QCDR	No benchmark					

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
NEURO-OPHTHALMOLOGY							
8.86%-6.22%	6.21%-2.99%	2.98%-0.60%	0.59%-0.01%			0%	Inverse measure, topped out
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9			10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
OCULOFACIAL PLASTICS/RECONSTRUCTIVE							
						100%	
						10.0	
						100%	Topped out, 7-point cap
						7.0	
						100%	Topped out, 7-point cap
						7.0	
						100%	Topped out, 7-point cap
						7.0	
99.74%-99.99%						100%	Topped out, 7-point cap
4.0-4.9						7.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d) d1 (Large)	d2 (Large)	d3	
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS								
Outcome	**IRIS49: Surgical Pediatric Esotropia: Postoperative Alignment**	QCDR	No benchmark					
Outcome	**IRIS50: Amblyopia: Interocular Visual Acuity**	QCDR	No benchmark					
REFRACTIVE SURGERY								
Outcome	**IRIS23: Refractive Surgery: Patients With a Postoperative Uncorrected Visual Acuity (UCVA) of 20/20 or Better Within 30 days**	QCDR	1*-10	**Performance rate**	24.29%-43.99%	44.00%-68.54%	68.55%-77.57%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS24: Refractive Surgery: Patients With a Postoperative Correction Within + or - 0.5 Diopter (D) of the Intended Correction**	QCDR	No benchmark					
RETINA								
Age-Related Macular Degeneration (AMD)								
	14: AMD: Dilated Macular Examination	MIPS CQM	1*-7	**Performance rate**	5.91%-74.54%	74.55%-89.15%	89.16%-93.78%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Other HP	**19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**	MIPS CQM	1*-4.9 or 7	**Performance rate**	3.33%-72.33%	72.34%-91.44%	91.45%-98.70%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
		eCQM	1*-10	**Performance rate**	6.41%-52.98%	52.99%-70.17%	70.18%-80.35%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS13: DME: Loss of Visual Acuity**	QCDR	1*-10	**Performance rate**	56.86%-80.43%	80.44%-84.61%	84.62%-86.51%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Outcome	**IRIS58: Improved Visual Acuity After Vitrectomy for Complications of Diabetic Retinopathy Within 120 Days**	QCDR	No benchmark					

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
PEDIATRIC OPHTHALMOLOGY AND STRABISMUS							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
REFRACTIVE SURGERY							
77.58%-81.24%	81.25%-82.34%	82.35%-84.20%	84.21%-89.19%	89.20%-94.28%	94.29%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
RETINA							
Age-Related Macular Degeneration (AMD)							
93.79%-96.30%	96.31%-98.07%	98.08%-99.13%	99.14%-99.76%	99.77%-99.99%		100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9	6.0-6.9	7.0	7.0		7.0	
98.71%-99.99%						100%	Topped out, 7-point cap
4.0-4.9						7.0	
80.36%-86.31%	86.32%-90.90%	90.91%-93.74%	93.75%-96.04%	96.05%-97.99%	98.00%-99.54%	≥99.55%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
86.52%-88.01%	88.02%-89.41%	89.42%-90.36%	90.37%-92.05%	92.06%-93.82%	93.83%-96.35%	≥96.36%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							

Table 4: Quality Measures Benchmarks

High Priority	ID: Measure Name	Type	Points		Benchmark Decile (d)			
					d1 (Large)	d2 (Large)	d3	
RETINA								
Epiretinal Membrane								
Out-come	**IRIS41: Improved visual acuity after epiretinal membrane treatment within 120 days**	QCDR	No benchmark					
Macular Hole								
Out-come	**IRIS46: Evidence of Anatomic Closure of Macular Hole Within 90 Days after Surgery as Documented by OCT**	QCDR	1*-10	**Performance rate**	4.17%-24.13%	24.14%-39.99%	40.00%-53.05%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Retinal Detachment								
Out-come	**384: Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery**	MIPS CQM	1*-5.9 or 7	**Performance rate**	75.76%-89.13%	89.14%-95.09%	95.10%-96.76%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Out-come	**385: Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery**	MIPS CQM	1*-10	**Performance rate**	6.52%-16.80%	16.81%-21.89%	21.90%-34.77%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
UVEITIS/IMMUNOLOGY								
Out-come	**IRIS17: Acute Anterior Uveitis: Post-Treatment Grade 0 Anterior Chamber Cells**	QCDR	1*-10	**Performance rate**	13.33%-32.19%	32.20%-49.99%	50.00%-60.74%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Out-come	**IRIS35: Improvement of Macular Edema in Patients With Uveitis**	QCDR	No benchmark					
Out-come	**IRIS51: Acute Anterior Uveitis: Post-Treatment Visual Acuity**	QCDR	1*-10	**Performance rate**	60.00%-84.43%	84.44%-87.90%	87.91%-91.29%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	
Out-come	**IRIS53: Chronic Anterior Uveitis: Post-Treatment Visual Acuity**	QCDR	1*-10	**Performance rate**	53.12%-78.68%	78.69%-83.99%	84.00%-86.35%	
				Points	1.0-1.9	2.0-2.9	3.0-3.9	

Key: EHR = Electronic health record; **Interm. outcome** = Intermediate outcome measure; **Other HP** = Other high priority measure.
* There is 3-point floor for small practices, provided that they report on at least one patient and, depending on their collection type, submit submit data-completeness totals (see page 25). Note: You may be able to report measures 14, 141, 384, 385, 389, and 493 via IRIS Registry–EHR integration. Although CMS didn't create electronic specifications for these six measures, the IRIS Regis-

Benchmark Decile (d)							Notes
d4	d5	d6	d7	d8	d9	d10	
RETINA							
Epiretinal Membrane							
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
Macular Hole							
53.06%-56.51%	56.52%-63.30%	63.31%-66.66%	66.67%-71.90%	71.91%-81.57%	81.58%-95.23%	≥95.24%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Retinal Detachment							
96.77%-98.25%	98.26%-99.99%					100%	Topped out, 7-point cap
4.0-4.9	5.0-5.9					7.0	
34.78%-38.77%	38.78%-56.93%	56.94%-62.27%	62.28%-64.70%	64.71%-77.28%	77.29%-81.47%	≥81.48%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
UVEITIS/IMMUNOLOGY							
60.75%-67.85%	67.86%-71.36%	71.37%-74.01%	74.02%-77.77%	77.78%-82.13%	82.14%-87.17%	≥87.18%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
Not enough data from 2021 to establish a historic benchmark for this measure. After the 2023 performance year is over, CMS will attempt to create a benchmark based on 2023 performance data.							
91.30%-93.78%	93.79%-95.44%	95.45%-95.91%	95.92%-97.25%	97.26%-99.25%	99.26%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	
86.36%-88.23%	88.24%-90.17%	90.18%-92.85%	92.86%-95.23%	95.24%-97.77%	97.78%-99.99%	100%	
4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10.0	

try was able to extract the necessary data for the first five of those measures from EHR systems in the past. Similarly, the Academy expects that the IRIS Registry will be able to extract data for measure 493, which is a new measure, from most EHR systems.

Look out for CMS corrections. Some years, CMS has published corrections to the benchmark data part way through the performance year. Stay alert for CMS corrections (see "Empower Your MIPS Team," page 7).

WHAT COULD SHE SEE THIS YEAR?

EYLEA®
(aflibercept) Injection
For Intravitreal Injection

Inspired by a real patient with DME.

375 MATH TESTS

IMPORTANT SAFETY INFORMATION
CONTRAINDICATIONS

- EYLEA is contraindicated in patients with ocular or periocular infections, active intraocular inflammation, or known hypersensitivity to aflibercept or to any of the excipients in EYLEA.

WARNINGS AND PRECAUTIONS

- Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately. Intraocular inflammation has been reported with the use of EYLEA.
- Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with VEGF inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.
- There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

EYLEA ACHIEVED RAPID, SUSTAINED OUTCOMES IN DME

Demonstrated efficacy outcomes in VISTA and VIVID, phase 3 anti-VEGF trials in DME (N=862)[1]

Mean change in BCVA (ETDRS letters) at Year 1 from baseline[1-5,*]

	Initial Gains (Month 5)		Primary Endpoint (Year 1)		Prespecified Exploratory Endpoint (Year 3)	
	VISTA	VIVID	VISTA	VIVID	VISTA	VIVID
EYLEA Q4	+10.3 (n=154)	+9.3 (n=136)	+12.5 (n=154)	+10.5 (n=136)	+10.4 (n=154)	+10.3 (n=136)
EYLEA Q8†	+9.9 (n=151)	+9.3 (n=135)	+10.7 (n=151)	+10.7 (n=135)	+10.5 (n=151)	+11.7 (n=135)
Control	+1.8 (n=154)	+1.8 (n=132)	+0.2 (n=154)	+1.2 (n=132)	+1.4 (n=154)	+1.6 (n=132)

P<0.01 vs control at Year 1.

The analyses of these exploratory endpoints were not multiplicity protected and are descriptive only.

Year 2 data was consistent with results seen in Year 1.[5]

VISTA and VIVID study designs: Two randomized, multicenter, double-masked, controlled clinical studies in which patients with DME (N=862; age range: 23-87 years, with a mean of 63 years) were randomized and received: 1) EYLEA 2 mg Q8 following 5 initial monthly doses; 2) EYLEA 2 mg Q4; or 3) macular laser photocoagulation (control) at baseline and then as needed. From Week 100, laser control patients who had not received EYLEA rescue treatment received EYLEA as needed per re-treatment criteria. Protocol-specified visits occurred every 28 (±7) days.[1]

In both clinical studies, the primary efficacy endpoint was the mean change from baseline in BCVA at Week 52, as measured by ETDRS letter score.[1]

*Last observation carried forward; full analysis set.
†Following 5 initial monthly doses.

SEE WHAT EYLEA COULD DO FOR YOUR PATIENTS WITH DME AT HCP.EYLEA.US

anti-VEGF, anti–vascular endothelial growth factor; BCVA, best-corrected visual acuity; ETDRS, Early Treatment Diabetic Retinopathy Study; Q4, every 4 weeks; Q8, every 8 weeks.

ADVERSE REACTIONS

- Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment.
- The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.
- Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations. Advise patients not to drive or use machinery until visual function has recovered sufficiently.

INDICATIONS

EYLEA® (aflibercept) Injection 2 mg (0.05 mL) is indicated for the treatment of patients with Neovascular (Wet) Age-related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), and Diabetic Retinopathy (DR).

References: 1. EYLEA® (aflibercept) Injection full U.S. Prescribing Information. Regeneron Pharmaceuticals, Inc. August 2019. **2.** Korobelnik JF, Do DV, Schmidt-Erfurth U, et al. Intravitreal aflibercept for diabetic macular edema. *Ophthalmology.* 2014;121(11):2247-2254. doi:10.1016/j.ophtha.2014.05.006 **3.** Brown DM, Schmidt-Erfurth U, Do DV, et al. Intravitreal aflibercept for diabetic macular edema: 100-week results from the VISTA and VIVID studies. *Ophthalmoogy.* 2015;122(10):2044-2052. doi:10.1016/j.ophtha.2015.06.017 **4.** Data on file. Regeneron Pharmaceuticals, Inc. **5.** Heier JS, Korobelnik JF, Brown DM, et al. Intravitreal aflibercept for diabetic macular edema: 148-week results from the VISTA and VIVID studies. *Ophthalmology.* 2016;123(11):2376-2385. doi:10.1016/j.ophtha.2016.07.032

Please see Brief Summary of Prescribing Information on the following page.

04/2021
EYL.21.03.0211

EYLEA®
(aflibercept) Injection
For Intravitreal Injection

BRIEF SUMMARY—Please see the EYLEA full Prescribing Information available on HCP.EYLEA.US for additional product information.

1 INDICATIONS AND USAGE
EYLEA is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of patients with:

Neovascular (Wet) Age-Related Macular Degeneration (AMD), Macular Edema Following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR).

4 CONTRAINDICATIONS

4.1 Ocular or Periocular Infections
EYLEA is contraindicated in patients with ocular or periocular infections.

4.2 Active Intraocular Inflammation
EYLEA is contraindicated in patients with active intraocular inflammation.

4.3 Hypersensitivity
EYLEA is contraindicated in patients with known hypersensitivity to aflibercept or any of the excipients in EYLEA. Hypersensitivity reactions may manifest as rash, pruritus, urticaria, severe anaphylactic/anaphylactoid reactions, or severe intraocular inflammation.

5 WARNINGS AND PRECAUTIONS

5.1 Endophthalmitis and Retinal Detachments
Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments [*see Adverse Reactions (6.1)*]. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately [*see Patient Counseling Information (17)*].

5.2 Increase in Intraocular Pressure
Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA [*see Adverse Reactions (6.1)*]. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with vascular endothelial growth factor (VEGF) inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.

5.3 Thromboembolic Events
There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

6 ADVERSE REACTIONS
The following potentially serious adverse reactions are described elsewhere in the labeling:
- Hypersensitivity [*see Contraindications (4.3)*]
- Endophthalmitis and retinal detachments [*see Warnings and Precautions (5.1)*]
- Increase in intraocular pressure [*see Warnings and Precautions (5.2)*]
- Thromboembolic events [*see Warnings and Precautions (5.3)*]

6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in other clinical trials of the same or another drug and may not reflect the rates observed in practice.
A total of 2980 patients treated with EYLEA constituted the safety population in eight phase 3 studies. Among those, 2379 patients were treated with the recommended dose of 2 mg. Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment. The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.

Neovascular (Wet) Age-Related Macular Degeneration (AMD). The data described below reflect exposure to EYLEA in 1824 patients with wet AMD, including 1223 patients treated with the 2-mg dose, in 2 double-masked, controlled clinical studies (VIEW1 and VIEW2) for 24 months (with active control in year 1).
Safety data observed in the EYLEA group in a 52-week, double-masked, Phase 2 study were consistent with these results.

Table 1: Most Common Adverse Reactions (≥1%) in Wet AMD Studies

	Baseline to Week 52		Baseline to Week 96	
Adverse Reactions	EYLEA (N=1824)	Active Control (ranibizumab) (N=595)	EYLEA (N=1824)	Control (ranibizumab) (N=595)
Conjunctival hemorrhage	25%	28%	27%	30%
Eye pain	9%	9%	10%	10%
Cataract	7%	7%	13%	10%
Vitreous detachment	6%	6%	8%	8%
Vitreous floaters	6%	7%	8%	10%
Intraocular pressure increased	5%	7%	7%	11%
Ocular hyperemia	4%	8%	5%	10%
Corneal epithelium defect	4%	5%	5%	6%
Detachment of the retinal pigment epithelium	3%	3%	5%	5%
Injection site pain	3%	3%	3%	4%
Foreign body sensation in eyes	3%	4%	4%	4%
Lacrimation increased	3%	1%	4%	2%
Vision blurred	2%	2%	4%	3%
Intraocular inflammation	2%	3%	3%	4%
Retinal pigment epithelium tear	2%	1%	2%	2%
Injection site hemorrhage	1%	2%	2%	2%
Eyelid edema	1%	2%	2%	3%
Corneal edema	1%	1%	1%	1%
Retinal detachment	<1%	<1%	1%	1%

Less common serious adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal tear, and endophthalmitis.

Macular Edema Following Retinal Vein Occlusion (RVO). The data described below reflect 6 months exposure to EYLEA with a monthly 2 mg dose in 218 patients following central retinal vein occlusion (CRVO) in 2 clinical studies (COPERNICUS and GALILEO) and 91 patients following branch retinal vein occlusion (BRVO) in one clinical study (VIBRANT).

Table 2: Most Common Adverse Reactions (≥1%) in RVO Studies

	CRVO		BRVO	
Adverse Reactions	EYLEA (N=218)	Control (N=142)	EYLEA (N=91)	Control (N=92)
Eye pain	13%	5%	4%	5%
Conjunctival hemorrhage	12%	11%	20%	4%
Intraocular pressure increased	8%	6%	2%	0%
Corneal epithelium defect	5%	4%	2%	0%
Vitreous floaters	5%	1%	1%	0%
Ocular hyperemia	5%	3%	2%	2%
Foreign body sensation in eyes	3%	5%	3%	0%
Vitreous detachment	3%	4%	2%	0%
Lacrimation increased	3%	4%	3%	0%
Injection site pain	3%	1%	1%	0%
Vision blurred	1%	<1%	1%	1%
Intraocular inflammation	1%	1%	0%	0%
Cataract	<1%	1%	5%	0%
Eyelid edema	<1%	1%	1%	0%

Less common adverse reactions reported in <1% of the patients treated with EYLEA in the CRVO studies were corneal edema, retinal tear, hypersensitivity, and endophthalmitis.

Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR). The data described below reflect exposure to EYLEA in 578 patients with DME treated with the 2-mg dose in 2 double-masked, controlled clinical studies (VIVID and VISTA) from baseline to week 52 and from baseline to week 100.

Table 3: Most Common Adverse Reactions (≥1%) in DME Studies

	Baseline to Week 52		Baseline to Week 100	
Adverse Reactions	EYLEA (N=578)	Control (N=287)	EYLEA (N=578)	Control (N=287)
Conjunctival hemorrhage	28%	17%	31%	21%
Eye pain	9%	6%	11%	9%
Cataract	8%	9%	19%	17%
Vitreous floaters	6%	3%	8%	6%
Corneal epithelium defect	5%	3%	7%	5%
Intraocular pressure increased	5%	3%	9%	5%
Ocular hyperemia	5%	6%	5%	6%
Vitreous detachment	3%	3%	8%	6%
Foreign body sensation in eyes	3%	3%	3%	3%
Lacrimation increased	3%	2%	4%	2%
Vision blurred	2%	2%	3%	4%
Intraocular inflammation	2%	<1%	3%	1%
Injection site pain	2%	<1%	2%	<1%
Eyelid edema	<1%	1%	2%	1%

Less common adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal detachment, retinal tear, corneal edema, and injection site hemorrhage.
Safety data observed in 269 patients with nonproliferative diabetic retinopathy (NPDR) through week 52 in the PANORAMA trial were consistent with those seen in the phase 3 VIVID and VISTA trials (see Table 3 above).

6.2 Immunogenicity
As with all therapeutic proteins, there is a potential for an immune response in patients treated with EYLEA. The immunogenicity of EYLEA was evaluated in serum samples. The immunogenicity data reflect the percentage of patients whose test results were considered positive for antibodies to EYLEA in immunoassays. The detection of an immune response is highly dependent on the sensitivity and specificity of the assays used, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to EYLEA with the incidence of antibodies to other products may be misleading.
In the wet AMD, RVO, and DME studies, the pre-treatment incidence of immunoreactivity to EYLEA was approximately 1% to 3% across treatment groups. After dosing with EYLEA for 24-100 weeks, antibodies to EYLEA were detected in a similar percentage range of patients. There were no differences in efficacy or safety between patients with or without immunoreactivity.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy
Risk Summary
Adequate and well-controlled studies with EYLEA have not been conducted in pregnant women. Aflibercept produced adverse embryofetal effects in rabbits, including external, visceral, and skeletal malformations. A fetal No Observed Adverse Effect Level (NOAEL) was not identified. At the lowest dose shown to produce adverse embryofetal effects, systemic exposures (based on AUC for free aflibercept) were approximately 6 times higher than AUC values observed in humans after a single intravitreal treatment at the recommended clinical dose [*see Animal Data*].
Animal reproduction studies are not always predictive of human response, and it is not known whether EYLEA can cause fetal harm when administered to a pregnant woman. Based on the anti-VEGF mechanism of action for aflibercept, treatment with EYLEA may pose a risk to human embryofetal development. EYLEA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Data
Animal Data
In two embryofetal development studies, aflibercept produced adverse embryofetal effects when administered every three days during organogenesis to pregnant rabbits at intravenous doses ≥3 mg per kg, or every six days during organogenesis at subcutaneous doses ≥0.1 mg per kg.
Adverse embryofetal effects included increased incidences of postimplantation loss and fetal malformations, including anasarca, umbilical hernia, diaphragmatic hernia, gastroschisis, cleft palate, ectrodactyly, intestinal atresia, spina bifida, encephalomeningocele, heart and major vessel defects, and skeletal malformations (fused vertebrae, sternebrae, and ribs; supernumerary vertebral arches and ribs; and incomplete ossification). The maternal No Observed Adverse Effect Level (NOAEL) in these studies was 3 mg per kg. Aflibercept produced fetal malformations at all doses assessed in rabbits and the fetal NOAEL was not identified. At the lowest dose shown to produce adverse embryofetal effects in rabbits (0.1 mg per kg), systemic exposure (AUC) of free aflibercept was approximately 6 times higher than systemic exposure (AUC) observed in humans after a single intravitreal dose of 2 mg.

8.2 Lactation
Risk Summary
There is no information regarding the presence of aflibercept in human milk, the effects of the drug on the breastfed infant, or the effects of the drug on milk production/excretion. Because many drugs are excreted in human milk, and because the potential for absorption and harm to infant growth and development exists, EYLEA is not recommended during breastfeeding.
The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for EYLEA and any potential adverse effects on the breastfed child from EYLEA.

8.3 Females and Males of Reproductive Potential
Contraception
Females of reproductive potential are advised to use effective contraception prior to the initial dose, during treatment, and for at least 3 months after the last intravitreal injection of EYLEA.

Infertility
There are no data regarding the effects of EYLEA on human fertility. Aflibercept adversely affected female and male reproductive systems in cynomolgus monkeys when administered by intravenous injection at a dose approximately 1500 times higher than the systemic level observed humans with an intravitreal dose of 2 mg. A No Observed Adverse Effect Level (NOAEL) was not identified. These findings were reversible within 20 weeks after cessation of treatment.

8.4 Pediatric Use
The safety and effectiveness of EYLEA in pediatric patients have not been established.

8.5 Geriatric Use
In the clinical studies, approximately 76% (2049/2701) of patients randomized to treatment with EYLEA were ≥65 years of age and approximately 46% (1250/2701) were ≥75 years of age. No significant differences in efficacy or safety were seen with increasing age in these studies.

17 PATIENT COUNSELING INFORMATION
In the days following EYLEA administration, patients are at risk of developing endophthalmitis or retinal detachment. If the eye becomes red, sensitive to light, painful, or develops a change in vision, advise patients to seek immediate care from an ophthalmologist [*see Warnings and Precautions (5.1)*].
Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations [*see Adverse Reactions (6)*]. Advise patients not to drive or use machinery until visual function has recovered sufficiently.

REGENERON

Manufactured by:
Regeneron Pharmaceuticals, Inc.
777 Old Saw Mill River Road
Tarrytown, NY 10591

Issue Date: 08/2019
Initial U.S. Approval: 2011

Based on the August 2019
EYLEA® (aflibercept) Injection full
Prescribing Information.

EYL.20.09.0052

YOU NEED A CERTIFIED EHR SYSTEM FOR THIS PERFORMANCE CATEGORY

How to Report Promoting Interoperability

Promoting interoperability (PI) is the MIPS performance category that is based on your use of EHRs. Its default weight in your MIPS final score is 25%, meaning that it can contribute up to 25 points to that score. However, if you are excused from PI (see page 48), that weight would be reallocated to one or more other performance categories (see Table 3, page 14).

Your EHR System Must Be a CEHRT

You must use a 2015-edition Cures Update CEHRT. To participate in the MIPS PI performance category, you'll need a certified EHR technology (CEHRT) that has 2015-edition Cures Update certification.

Check your EHR system's certification. To check the certification status of an EHR product at any given time, visit the Certified Health IT Product List (CHPL) at https://chpl.healthit.gov/#/search. (Make a note of your system's CHPL ID#; you will need this when you report your PI performance to CMS.)

What if your EHR system's certification is still pending? CMS recognizes that some vendors may be providing upgraded EHR systems to practices while certification is still pending. If this is the case with your EHR system, you may still be able to satisfy the CEHRT requirement provided:

- your EHR system has 2015-edition Cures Update functionality for all 90+ days of your PI performance period, and
- CMS grants the certification by the last day of that performance period.

What if not all your EHR systems are certified? If your practice has one EHR system that doesn't have 2015-edition Cures Update certification and another EHR system that does, only submit data that was collected in the latter

EHR certification and the quality performance category. If you report electronic clinical quality measures (eCQMs), your EHR system must have 2015-edition Cures Update certification. During a Nov. 16, 2022, webinar, CMS staff stated that your EHR system doesn't need that certification on Jan. 1, 2023, but it does need it before you start generating the eCQM data that you will report to CMS.

Promoting Interoperability 101

Default weight in MIPS final score: 25%.

Performance period: The same 90+ consecutive days for all scored measures, but the two unscored measures (Security Risk Analysis measure and High Priority Practices of the SAFER Guides measure) can be performed at any time of the calendar year.

Performance requirements: Meet the following requirements:

- Use an EHR system that has 2015–edition Cures Update certification (see "Your EHR System Must Be a CEHRT," above), and provide CMS with your EHR system's CHPL identification code;
- perform the unscored Security Risk Analysis measure;
- perform the unscored High Priority Practices of the SAFER Guides measure;
- perform and report—or, where applicable, claim an exclusion for—all the mandatory scored measures;
- make four attestations (regarding the Security Risk Analysis; High Priority Practices Guide of the SAFER Guides; Prevention of Information Blocking, and ONC Direct Review); and
- document your performance in case of an audit.

Collection types: Like last year, you can report your PI measures manually via the IRIS Registry, via the CMS QPP attestation portal, or possibly via your EHR vendor (check that your vendor offers this option, and ask about deadlines and fees).

Warning: You'll get a PI score of 0% if you submit conflicting data or conflicting attestations on PI measures. (This could happen, for example, if you report PI twice using two different collection types and submit different information each time.)

Not everybody has to take part in PI. In some cases, you may be excused from performing the PI measures (see page 48).

Performance Period Is At Least 90 Days

Pick a performance period of at least 90 continuous days and no more than the calendar year.

Pick your date range. You must use the same performance period—i.e., same start date and same end date—for each of the scored PI measures that you report. Monitor your data all year and pick the date range with the highest performance rates.

The two unscored measures can be done on a separate schedule. The Security Risk Analysis

measure and the High Priority Practices Guide of the SAFER Guides measure don't have to be done during the performance period that you are using for the scored PI measures. They can be done at any time during the 2023 calendar year. However, the two measures must address the same 2015-edition Cures Update CEHRT that is used to perform the scored measures.

Last day to start performing PI measures is Oct. 3. Don't wait until October; make sure you allow yourself some leeway in case you run into problems.

What you should be doing early in the year. Make sure you understand the PI measures and know what you need to do to meet their requirements. Read the measure descriptions and documentation suggestions at aao.org/medicare/promoting-interoperability/measures. Your EHR system should allow you to run PI reports; run them to see what your performance rates are. If performance rates seem low, try to pinpoint the source of the problem—are data being entered into the right field? Do you need to make changes to workflow? If any physicians have joined your practice this year, make sure they are included in the reports.

Document measure performance. Make sure your documentation includes dates, so you can show that you met the performance period requirements. You won't need to provide this documentation when you report your PI measures, but you should keep it for six years in case you are audited.

Promoting Interoperability Is Structured Around Four Objectives

PI is arranged around four objectives:

- e-Prescribing (under PI's default scoring, this objective contributes up to 20 points to your PI score)
- Health Information Exchange (contributes up to 30 points, down from 40 points in 2022)
- Provider to Patient Exchange (contributes up to 25 points, down from 40 points in 2022)
- Public Health and Clinical Data Exchange (contributes up to 25 points plus 5 bonus points, up from 15 points plus 5 bonus points in 2022)

Each objective has at least one measure associated with it (review the measure descriptions at at aao.org/medicare/promoting-interoperability/measures).

Exclusions are available for some—but not all—PI measures. If you successfully apply for an exclusion to a PI measure, the PI points that were available for that measure will be reassigned to one or more other PI measures, as shown in Table 5 (next page).

All or nothing: Fall short with a required measure and your PI score will be 0%. In order to score more than 0% for the PI performance category, you must either 1) report or 2), if an exclusion is available, claim an exclusion for all the required measures. If you fail to do that, your PI score will be 0% and will contribute 0 points to your MIPS final score. (Note: When you report a numerator, it must be at least 1.)

The E-Prescribing Objective

This objective involves reporting—or claiming the exclusions for—two measures: the e-Prescribing measure and the Query of Prescription Drug Monitoring Program (PDMP) measure.

e-Prescribing measure. Either report your performance rate or claim an exclusion for this measure. If you perform this measure, which involves transmitting prescriptions using your CEHRT, you will be scored based on your performance rate (see "Performance Rate–Based Measures," page 48).

Exclusion for e-Prescribing measure. You can claim an exclusion from this measure if you write "fewer than 100 permissible prescriptions during the performance period." If you claim this exclusion, the points associated with this measure will be redistributed to the Health Information Exchange objective.

Query of Prescription Drug Monitoring Program (PDMP) measure. In 2022, this was an optional bonus measure that focused on Schedule II opioids. This year, the measure has been expanded to include Schedule III and IV drugs and you must either attest that you met its requirements or report an exclusion. The measure's expanded description is as follows: "For at least one Schedule II opioid or Schedule III or IV drug electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history."

What are PDMPs? PDMPs are electronic databases that track prescriptions for controlled substances. CMS says that there is a PDMP in each state.

What are Schedule II, III, and IV drugs? Unlike Schedule I substances (such as heroin), Schedule II, III, and IV substances all have accepted medical uses but are open to abuse.

Schedule II drugs have a high potential for abuse. Such abuse can lead to moderate or low physical dependence or high psychological dependence. According to CMS, examples include "Hydrocodone, methadone, Demerol, OxyContin, Percocet, morphine, codeine, and amphetamine."

Compared with Schedule II drugs, there is less potential for abuse with Schedule III and IV drugs. Examples of Schedule III drugs include, "Tylenol with codeine and anabolic steroids." Examples of Schedule IV drugs include "Xanax, Klonopin, Valium, and Ativan."

Exclusions for Query of PDMP measure. You can claim an exclusion from the Query of PDMP measure in the following circumstances: 1) if you write fewer than 100 permissible prescriptions during the performance period and/or 2) if you are unable to prescribe Schedule II, III, and IV drugs in accordance with applicable law and/or—for 2023 only—3) if querying a PDMP "would impose an excessive workflow or cost burden" prior to the start of your PI performance period. If you claim one of these exclusions, CMS will reassign the points associated with this measure to the e-Prescribing measure.

Health Information Exchange (HIE) Objective

With this objective, you select one of three options (up from two options in 2022).

Option 1: report your performance rate(s)—or claim the exclusion(s)—for the two Support Electronic Referral Loops measures.

Option 2: attest that you performed the HIE Bi-Direc-

tional Exchange measure (this option is unlikely to apply to private ophthalmology practices).

New for 2023—option 3: report on the Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) measure.

What is TEFCA? TEFCA features a technical infrastructure model that is intended to provide a minimum level of interoperability, thus helping users to exchange clinical information securely. Qualified Health Information Networks (QHINs) are being encouraged to sign an agreement that promotes the use of TEFCA.

The new TEFCA measure. This new measure involves signing a Framework Agreement, connecting directly to a QHIN (or connecting to an entity that connects to a QHIN), and using CEHRT to support secure, bidirectional exchange of patient information in accordance with TEFCA.

Exclusions. For the HIE objective, only the two Support Electronic Referral Loops measures have exclusions.

Exclusion for the Support Electronic Referral Loops by *Sending* Health Information measure. Exclusion: "Any

Table 5: Promoting Interoperability (PI)—at a Glance

To get a PI score of more than 0%, you must perform all of the following steps:

❶ have 2015-edition Cures Update CEHRT;
❷ submit a "Yes" for the Security Risk Analysis attestation;
❸ submit a "Yes" for the SAFER Guides attestation;
❹ submit a "Yes" for the Prevention of Information Blocking attestation;
❺ submit a "Yes" for the ONC Direct Review attestation; and meet the reporting requirements for ❻; ❼; ❽ or ❾ or ❿; ⓫; and ⓬, as shown below. (The measures listed below must be performed for a performance period of at least 90 consecutive days.)

2023 PI Measure	Reporting Requirements	Points	Point Reallocation if Exclusion Applies
e-Prescribing Objective			
❻ **e-Prescribing**	Either (a) report the performance rate (numerator/denominator) with a numerator of at least 1 or (b) claim an exclusion.	Up to 10	The 10 points (or 20 points if you claim an exclusion for both of this objective's measures) would be distributed to the HIE objective.
❼ **Query of Prescription Drug Monitoring Program (PDMP)**	Either (a) attest "yes" or (b) claim an exclusion.	0 or 10	The 10 points would be redistributed to the e-Prescribing measure.
Health Information Exchange (HIE) Objective [perform ❽ or ❾ or ❿]			
❽a **Support Electronic Referral Loops by *Sending* Health Information**	Either (a) report the performance rate (numerator/denominator) with a numerator of at least 1 or (b) claim an exclusion.	Up to 15	The 15 points (or 30 points if you claim an exclusion for both Referral Loops measures) would be distributed to the Provider to Patient Exchange objective.
❽b **Support Electronic Referral Loops by *Receiving and Reconciling* Health Information**	Either (a) report the performance rate (numerator/denominator) with a numerator of at least 1 or (b) claim an exclusion.	Up to 15	The 15 points would be redistributed to the Support Electronic Referral Loops by *Sending* Health Information measure.
❾ **HIE Bi-Directional Exchange** (unlikely to apply to private ophthalmology practices)	Three "yes" or "no" attestations relating to your EHR's support of bi-directional exchange of health information.	0 or 30	No exclusion available: If you don't report this measure or the TEFCA measure, you can instead report (or claim exclusions for) the two Referral Loops measures.
❿ **Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA)**	Two "yes" or "no" attestations relating to your participation in a TEFCA.	0 or 30	No exclusion available: If you don't report this measure or the Bi-Directional measure, you can instead report (or claim exclusions for) the two Referral Loops measures.

Provider to Patient Exchange Objective			
11 Provide Patients Electronic Access to Their Health Information	Report the performance rate (numerator/denominator) with a numerator of at least 1. (No exclusion for this measure.)	Up to 25	No exclusion available for this mandatory measure.
Public Health and Clinical Data Exchange Objective			
12a Immunization Registry Reporting	Either (a) attest "yes" to both measures or (b) attest "yes" to one and claim an exclusion for the other to earn 25 points. Or (c) claim exclusions for both measures.	0 or 25	If you claim exclusions for both measures, the points are redistributed to the Provide Patients Electronic Access to Their Health Information measure.
12b Electronic Case Reporting			
Public Health Registry Reporting	Attest "yes" to at least one measure to earn the 5 bonus points. If you integrate your EHR with the IRIS Registry, you can report the Clinical Data Registry Reporting measure. (No extra bonus points for reporting more than one measure.)	0 or 5 (bonus)	Optional measures, so no exclusions are needed.
Clinical Data Registry Reporting			
Syndromic Surveillance Reporting			
2023 PI score is the sum of your measure scores (capped at 100 points, and reported as a percentage).		0%-100%	
Contribution to MIPS final score. If PI is weighted at 25% of your MIPS final score (which is the default weight), it can contribute up to 25 points to your MIPS final score (0-100 points).			

MIPS eligible clinician who transfers a patient to another setting or refers a patient [a combined total of] fewer than 100 times during the performance period."

Exclusion for the Support Electronic Referral Loops by *Receiving and Reconciling* Health Information measure. Exclusion: "Any MIPS eligible clinician who receives transitions of care or referrals or has patient encounters in which the MIPS eligible clinician has never before encountered the patient [a combined total of] fewer than 100 times during the performance period." (Note: It is unlikely that a large practice would fall below this threshold over 90 days.)

If you claim exclusions for both of the Referral Loops measures, the points associated with them would be redistributed to the Provider to Patient Exchange objective.

No exclusions for options 2 or 3. CMS didn't provide exclusions for the HIE Bi-Directional Exchange measure or the TEFCA measure because you can report (or claim exclusions for) the two Referral Loops measures instead.

Tip: If your EHR system is a CEHRT, it must provide you with a HIPAA-compliant Direct messaging service that supports the referral loop measures. Ask your vendor for your clinicians' direct addresses (or electronic end point) and add them to their National Plan and Provider Enumeration System (NPPES) profiles. For more information, see "MIPS 2021—How to Boost Your Promoting Interoperability Score" (*EyeNet*, August 2021) at aao.org/eyenet/archive.

Provider to Patient Exchange Objective

Report your performance rate for the Provide Patients Electronic Access to Their Health Information measure. Meet this measure's requirement for at least one patient.

What does electronic access involve? For this objective's measure, electronic access must involve providing the patient (or the patient's authorized representative) with both of the following:

- "Timely access to view online, download, and transmit his or her health information;" and
- Access to their health information using "any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's certified electronic health record technology (CEHRT)."

For more detailed information on this measure see its listing at aao.org/medicare/promoting-interoperability/measures.

No exclusion. When CMS revamped PI in 2019, it described the Provide Patients Electronic Access measure as the "crux" of the performance category, which is why it decided not to provide an exclusion for the measure.

Public Health and Clinical Data Exchange Objective

Report your performance rate—or claim an exclusion—for these two measures:

- Immunization Registry Reporting
- Electronic Case Reporting

You also can earn 5 bonus points by reporting any of the three optional measures:

- Public Health Registry Reporting
- Clinical Data Registry Reporting (e.g., IRIS Registry)
- Syndromic Surveillance Reporting

Note: You are eligible for this bonus even if you claim exclusions for both the Immunization Registry Reporting

measure and the Electronic Case Reporting measure. You get the same number of bonus points (5) whether you report one, two, or three of the optional measures.

New for 2023: A revised definition of active engagement. All five measures in this objective involve your active engagement in reporting to either a registry or a public health agency (PHA). For the 2023 performance year, you have two options for demonstrating active engagement:

1) preproduction and validation or
2) validated data production

(Previously there were three options: 1) completing a registration to submit data, 2) testing and validating the electronic submission of data, and 3) electronically submitting production data.)

New for 2023: Report your level of engagement. When you report that you met the requirements for any of the five measures in this objective, you must now also attest to your level of engagement (either validated data production or preproduction and validation).

What if you are reporting as a group? If your practice is reporting MIPS as a group, CMS has said that you should select the level of engagement that "best reflects the composition of the group (for example, the level that reflects the status of the majority of the MIPS eligible clinicians in the group.)" The agency also has said that your group can attest "yes" for this objective's two required measures if one MIPS eligible clinician meets the measures' requirements.

New for next year: A timetable for full engagement. Starting with the 2024 performance year, you will only be able to report the preproduction and validation level of engagement for a measure once before moving on to the validated data production level the next time you report that measure. This assumes that you are involved with the same registry or PHA in both years; if you switch to a different organization, you will be able to spend an additional year in preproduction and validation. (Note: CMS has said that it won't take into account your level of engagement for 2023. If you are in preproduction and validation in 2023, you will be able to stay at that level of engagement in 2024 before being obligated to move to validated data production in 2025.)

Exclusions. Exclusions are available for the two required measures, but not for the three optional measures.

Exclusion for the Immunization Registry Reporting measure. You can qualify for an exclusion if one or more of these three criteria applies:

- "Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period."
- "Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the performance period."
- "Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of six months prior to the start of the performance period."

Exclusion for the Electronic Case Reporting measure. You can qualify for an exclusion if one or more of these three criteria applies:

- "Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period."
- "Operates in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the performance period."
- "Operates in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the performance period."

If you claim exclusions for both of this objective's required measures, the points associated with them would be redistributed to the Provider to Patient Exchange objective.

What Is Electronic Case Reporting?

The Electronic Case Reporting measure is one of two required measures under PI's Public Health and Clinical Data Exchange objective.

What is case reporting? States require health care providers to report certain diseases and conditions to public health agencies (PHAs). This process—known as case reporting—helps PHAs to track scores of diseases and conditions. Case reporting also provides data that facilitates prevention measures, such as contact tracing, and can further research.

Moving to electronic case reporting. Traditionally, case reporting has been done by phone, fax, mail, or, more recently, email. CMS argues that those methods have contributed to reporting delays, underreporting, and incomplete or inaccurate case data. The agency hopes that health care can overcome those problems by using electronic case reporting, which it describes as "the automated, real-time, bidirectional exchange of case report information between EHRs and PHAs."

For a list of PHA websites that provide information on their interoperability efforts, visit www.healthit.gov/isa/appendix-iv-state-and-local-public-health-readiness-interoperability.

Four Critical Attestations

You must submit the four attestations below. Failure to do so will result in a PI score of 0%.

Submit "yes" to attest that you performed the Security Risk Analysis. The Security Risk Analysis must be documented (in case of an audit), it must be done at some point during the 2023 performance year, and it must involve an analysis of the CEHRT that you have in place during your 90-day PI performance period, but it doesn't have to take place during that 90-day performance period. This Security Risk Analysis is also a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

Is your security review sufficiently thorough? To help you

with your review, you can download a Security Risk Analysis Tool at www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool.

Submit "yes" for the SAFER Guides attestation. The High Priority Practices guide is one of nine Safety Assurance Factors for EHR Resilience (SAFER) guides developed by the Office of National Coordinator for Health Information Technology (ONC). CMS wants practices to conduct a self-assessment of EHR resiliency based on the High Priority Practices guide. You can download a fact sheet on the High Priority Practices guide from the Resource Library at https://qpp.cms.gov. From the fact sheet, you can link to a PDF of the guide, which includes a checklist of what you need to do.

Submit "yes" for the Prevention of Information Blocking attestation. Attest "yes" that you "did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability" of CEHRT.

Submit "yes" for the ONC Direct Review attestation. The ONC is responsible for certifying EHR systems as CEHRTs, and for monitoring CEHRTs to make sure they continue to meet their certification requirements. Occasionally, ONC may need to conduct a "direct review" of a vendor's EHR product (for example, if ONC has a reasonable belief that faults within the EHR system may present a risk to public health). By submitting "yes" to this attestation, you agree to cooperate in such a review.

Performance Rate–Based Measures

For some PI measures, scoring is based on your performance rate. You can, for example, score up to 10 points for the e-Prescribing measure. If, for instance, your e-Prescribing performance rate is 82%, you would score 8 points. (Note: In calculating this point score, CMS typically rounds off to the nearest whole number. The exception is when the nearest whole number is 0 points; provided you have reported on at least one patient, CMS will round up to 1 point.)

Your performance rate is based on a numerator and a denominator. For the e-Prescribing measure, to continue the example, the denominator is the number of prescriptions written during the performance period for drugs that require prescriptions, and the numerator is the number of those prescriptions that were 1) generated, 2) queried for a drug formulary, and 3) transmitted electronically using a certified EHR. You need a numerator of at least 1 to successfully report the measure. (For information on the numerators and denominators of the performance rate–based measures, see the detailed measure descriptions at aao.org/medicare/promoting-interoperability/measures; for tips on the Provide Patients Electronic Access to Their Health Information measure, see aao.org/practice-management/article/mips-tips-provide-patients-electronic-access.)

Reporting PI as a Group

If the MIPS eligible clinicians in your practice are reporting a performance category as a group, they must aggregate their performance data across the group's TIN (see "Use of TINs and NPIs as Identifiers," page 16). However, for the PI performance category, you would only use the performance data of those clinicians for whom you have data in a 2015-edition Cures Update CEHRT.

Some Clinicians May Be Excused From PI

In limited circumstances, you may be excused from PI reporting. Typically, if you don't report PI measures, your PI score will be 0% and your maximum MIPS final score would be 75 points. However, there are some exceptions (see below). If you qualify for an exception, you would be excused from reporting PI measures. Some PI exceptions must be applied for, while others are automatic.

What happens if you are excused from PI? If CMS excuses you from reporting PI, the performance category's weighting within your MIPS final score could be reallocated to one or more other performance categories as shown in "Table 3: How the Performance Categories Are Weighted" (page 14).

Warning: If you do any PI reporting for the 2023 performance year, you will have waived your right to any exception from PI. Suppose you qualify for a PI exception, but you report PI measures anyway. CMS will assume that you decided to participate in PI, will assign you a PI score, and will give PI a default weight of 25% in your MIPS final score.

Caveat for group-level reporting. If you are participating in MIPS as part of a group (rather than as an individual), you won't be excused from PI unless all MIPS eligible clinicians in the group are excused from PI.

Some PI Exceptions Must Be Applied For

You may apply for a significant hardship exception. CMS has described several circumstances in which you can apply for the significant hardship exception:

- insufficient internet connectivity and insurmountable barriers prevented you from obtaining sufficient access;
- extreme and uncontrollable circumstances that caused your CEHRT to become unavailable (see page 17), including disaster, practice closure, severe financial distress (e.g., bankruptcy or debt restructuring), and vendor issues;
- you have no control over whether CEHRT is available (you must be able to show that more than 50% of your patient encounters occurred in locations where you had no control over the availability of CEHRT); and/or
- you're using a decertified EHR system that lost its certification in 2022 or 2023 (note: you must be able to show a good-faith effort to replace it with a CEHRT ahead of the performance period, and you can't be granted this exception for more than five years).

Note: If your practice lacks an EHR system, that is not enough, in and of itself, to excuse you from PI.

Submit your application by Dec. 31, 2023. At time of press, CMS hadn't opened the application process for exceptions. When it does so, it will post a link at at https://qpp.cms.gov/mips/exception-applications. For some Academy guidance on the application process, visit aao.org/medicare/promoting-interoperability/exceptions. Note: If you applied for this exception in 2022 and it was approved, the approval doesn't roll over to 2023—you need to reapply.

Some PI Exceptions Are Automatic

You're in a disaster zone. If your practice is in an area that CMS has identified as being affected by extreme and uncontrollable circumstances (see page 17), CMS may excuse you from MIPS provided you don't report any MIPS data.

You are in a small practice. If you don't report on PI and CMS has designated your practice size as small, a hardship exception will automatically apply.

Certain types of MIPS eligible clinicians qualify for automatic reweighting. These include the following clinician types:

- hospital-based clinicians,
- ambulatory surgical center (ASC)–based clinicians,
- non–patient-facing clinicians,
- physical therapists,
- occupational therapists,
- qualified speech-language pathologists,
- registered dietitians or nutrition professionals, and
- clinical social workers.

Note: Automatic reweighting no longer applies to physician assistants, nurse practitioners, clinical nurse specialists, or certified registered nurse anesthetists.

Reminder. Although you may be eligible for a PI exception, you will waive your right to that if you submit any PI data to CMS.

Table 6: Promoting Interoperability's Scoring Methodology—an Example

PI scoring in action. The example below shows how numerators and denominators are used to calculate performance rates, which are themselves used to determine your measure scores. For detailed descriptions of what will fall within the numerator and denominator of the performance rate–based measures, see the measure listings at aao.org/medicare/promoting-interoperability/measures.

Objective	2023 PI Measure	Points Available	Numerator/ Denominator	Performance Rate	Points Scored
e-Prescribing	e-Prescribing	Up to 20	200/250	80%	80% of 20 = 16
	Query of Prescription Drug Monitoring Program (PDMP)	Claimed an exclusion, and the measure's 10 points were redistributed to the e-Prescribing measure.			
Health Information Exchange	Support Electronic Referral Loops by *Sending* Health Information	Up to 15	135/185	73%	73% of 15 = 10.95
	Support Electronic Referral Loops by *Receiving and Reconciling* Health Information	Up to 15	140/175	80%	80% of 15 = 12
	HIE Bi-Directional Exchange	Didn't choose this option; reported the two Support Electronic Referral Loops measures instead.			
	Enabling Exchange Under TEFCA	Didn't choose this option; reported the two Support Electronic Referral Loops Measures instead.			
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Up to 50*	350/500	70%	70% of 50 = 35
Public Health and Clinical Data Exchange	Immunization Registry Reporting	0*	Claimed exclusion	N/A	0*
	Electronic Case Reporting		Claimed exclusion	N/A	
	Public Health Registry Reporting	0 or 5 (bonus)			5
	Clinical Data Registry Reporting		Has integrated EHR with IRIS Registry; attested "yes"	N/A	
	Syndromic Surveillance Reporting				
Total points available:		105	Total points scored:		78.95
2023 PI score is sum of your measure scores (capped at 100 points, and reported as a percentage)					78.95%

Contribution to MIPS final score. If PI is weighted at 25% of your MIPS final score (which is the default weight), it can contribute up to 25 points to your MIPS final score—e.g., a PI score of 78.95% contributes 19.7 points (78.95% of 25).

* Exclusions were claimed for Immunization Registry Reporting and Electronic Case Reporting. This means that the 25 points for those two measures are redistributed to the Provider to Patient Exchange objective.

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MAX OUT YOUR SCORE FOR THIS PERFORMANCE CATEGORY

How to Succeed With Improvement Activities

The improvement activities performance category is largely the same as last year, though there are some changes to the improvement activities that can be reported via the IRIS Registry (see "2023 Versus 2022," next page).

How You Will Be Scored

Scoring for this performance category is the same as in 2022. To max out your score, you will need to successfully perform one to four improvement activities—the number that you need to perform depends on how those activities are weighted, as well as the size and location of your practice (see "Who scores double?" below).

You typically need to perform each activity for at least 90 consecutive days.

How many points do you get for an improvement activity? This depends on 1) how the activity is weighted and 2) whether you're able to double the score.

If an activity's weight is:

- medium—it scores 10 points (double score is 20 points)
- high—it scores 20 points (double score is 40 points)

Who scores double? MIPS participants can score double for an improvement activity if they have one of these special statuses:

- small practice (fewer than 16 eligible clinicians; see "Small or Large Practice?" on page 16),
- rural practice (zip codes will be considered rural based on the most recent Federal Office of Rural Health Policy data files on eligible zip codes),
- practice that is in a geographic health professional shortage area (HPSA), or
- non–patient-facing MIPS eligible clinicians.

Are you a non–patient-facing clinician? Probably not. Few ophthalmologists are likely to fall within this category. You are designated a non–patient-facing MIPS clinician if you bill Medicare for no more than 100 patient-facing encounter codes—including Medicare telehealth services—in a designated period.

Check whether CMS doubles your score. To see if you fall within one of the special status categories, use the CMS Participation Status tool. (See "What's Your MIPS Participation Status?" on page 16.)

Maximum score is capped at 40 points. If you don't have a special status that doubles your score, you can accrue the maximum score of 40 points by performing either:

- two high-weighted activities (2 × 20 points)
- two medium-weighted activities (2 × 10 points) and one high-weighted activity (1 × 20 points), or
- four medium-weighted activities (4 × 10 points).

If you are eligible to score double, you can accrue 40 points by performing:

- one high-weighted activity (1 × 40 points) or
- two medium-weighted activities (2 × 20 points).

Each improvement activity is all or nothing. You won't score points for an activity unless it is performed for the required time—typically a minimum of 90 consecutive days—and you satisfy all of its requirements. You do not score partial credit for reporting a partially performed activity.

Some MIPS participants will automatically get credit. MIPS eligible clinicians (and groups) who are practicing as part of an accredited patient-centered medical home (or comparable specialty practice) will automatically score 40 points (the maximum score); those who are participating as part of an advanced alternative payment model (APM) will automatically score a minimum of 20 points (half the maximum score). Few ophthalmologists are expected to fall within these two categories in 2023.

Improvement Activities 101

Default weight in MIPS final score: 15%.

Performance period: At least 90 continuous days for most activities.

How to score 100%: Practices with a special status—such as small or rural practices—should perform one high-weighted activity *or* two medium-weighted activities. Other practices should perform two high-weighted activities *or* one high-weighted and two medium-weighted activities *or* four medium-weighted activities.

Document your performance: Make sure you include dates. (As with all MIPS documentation, keep it for at least six years.)

Group reporting: If your practice is reporting as a group, each improvement activity must be performed by at least 50% of the group's clinicians.

Your improvement activities score (0-40 points) is turned into a percentage, which contributes up to 15 points to your MIPS final score. CMS divides your total number of points by 40 and turns the resulting fraction into a percentage (e.g., a score of 40 points would be 100%). Under the default weight, this contributes up to 15 points to your MIPS final score (e.g., a score of 100% would contribute 15 points).

Decide How You Will Report

Decide how you will attest. You can attest to your improvement activities performance via the IRIS Registry, the CMS QPP portal, or possibly your EHR vendor (ask your vendor whether it offers this option and what fees are involved).

Attest that you successfully completed improvement activities. However you decide to attest, it is your responsibility to attest that you appropriately completed the improvement activities that you choose to perform. If you attest via a third party (e.g., the IRIS Registry), the third party simply reports to CMS what you attested—the third party is not confirming that you did in fact complete those activities.

Group-level reporting. Practices that report as a group will only score points for an improvement activity if at least 50% of the practice's clinicians meet the reporting requirements of that activity (e.g., in a practice of nine, at least five). They must do each activity for a performance period of at least 90 consecutive days, but they don't all have to do it during the same date range.

2023 Versus 2022

The improvement activities performance category is largely the same as last year, but there have been changes to the activities that can be reported via the IRIS Registry.

10 additional activities available. Look for the asterisked activities in Table 7 (next page).

Major revisions to some activities. Four improvement activities underwent significant revisions, with two of them being renamed to reflect their shift in focus:

- IA_AHE_12: Practice improvements that engage community resources to address drivers of health (was previously IA_CC_14: Practice improvements that engage community resources to support patient health goals)
- IA_CC_13: Practice improvements to align with OpenNotes principles (was previously IA_CC_13: Practice improvements for bilateral exchange of patient information)
- IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements
- IA_PSPA_19: Implementation of formal quality improvement methods, practice changes, or other practice improvement processes

Three activities removed. CMS eliminated the following activities:

- IA_PM_7: Use of QCDR for feedback reports that incorporate population health
- IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program (PDMP)
- IA_PSPA_20: Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes

Select, Perform, and Document Your Activities

MIPS includes more than 100 improvement activities, but many of them aren't suitable for ophthalmologists.

Which improvement activities are most relevant to ophthalmology? The IRIS Registry supports reporting of the 66 improvement activities that are most meaningful for ophthalmology practices (see Table 7, next page).

Select which activities you will perform. You should be able to score 100% for this performance category. To do so, the number of improvement activities that you need to perform can range from one to four, depending on the activities' weights and whether you score double (see "How You Will Be Scored," previous page).

Some improvement activities were designed for QCDRs, such as the IRIS Registry. The improvement activities performance category seeks to leverage the capability of qualified clinical data registries (QCDRs). For example, IRIS Registry–EHR integration facilitates performance of IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements (medium weighted)

Get credit for MIPS *and* MOC. You can design and implement a quality improvement project that meets the requirements of the medium-weighted Continuing Certification (Maintenance of Certification) improvement activity IA_PSPA_2 (see page 65 for the activity's formal description). Your project will need to meet the requirements of the American Board of Ophthalmology (ABO). For further information, visit the ABO's website at https://abop.org/IRIS.

The performance period is typically 90 days. In order to score points for an improvement activity, you—or at least 50% of your colleagues, if you are reporting as part of a group or virtual group—must perform that activity for the performance period, which is typically at least 90 consecutive days. When groups perform an activity, each clinician can choose his or her own 90-day period within the 2023 calendar year.

Document your improvement activities. Ensure that you're ready for a future audit by maintaining documentation that shows you performed the improvement activities for which you are claiming credit. For each activity, CMS has published suggestions for suitable documentation. (To see detailed web pages that list CMS' documentation suggestions for all the activities that can be reported via the IRIS Registry, go to aao.org/medicare/improvement-activities.)

In case of an audit, can you prove that improvement activities were performed for the required time? When you document your performance of improvement activities, make sure you include dates so you can prove that you performed the activities for the required time, which is typically at least 90 days. As with all MIPS documentation, maintain your activities' documentation for at least six years.

Table 7: Improvement Activities—at a Glance

Which improvement activities should you perform? The IRIS Registry supports reporting of the 66 improvement activities that are most relevant to ophthalmology (listed below). To determine which of those would be most appropriate for your practice, review the activity descriptions in Table 8 (page 57), as well as the detailed specifications and documentation suggestions at aao.org/medicare/improvement-activities.

	ID#	Improvement Activity	Notes
HIGH-WEIGHTED ACTIVITIES			
		Achieving Health Equity	
page 57	IA_AHE_1	Enhance engagement of Medicaid and other underserved populations	No EHR required
	IA_AHE_3	Promote use of patient-reported outcome tools	No EHR required
	IA_AHE_6	Provide education opportunities for new clinicians	No EHR required
	IA_AHE_8*	Create and implement antiracism plan	No EHR required
page 58	IA_AHE_11*	Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer patients	No EHR required
	IA_AHE_12	Practice improvements that engage with community resources to address drivers of health	No EHR required
		Beneficiary Engagement	
page 58	IA_BE_6	Regularly assess patient experience of care and follow up on findings	No EHR required
	IA_BE_14	Engage patients and families to guide improvement in the system of care	No EHR required
59	IA_BE_25*	Drug cost transparency	No EHR required
		Emergency Response and Preparedness	
page 59	IA_ERP_2	Participation in a 60-day or greater effort to support domestic or international humanitarian needs	No EHR required
	IA_ERP_3	COVID-19 clinical data reporting with or without clinical trial	Facilitated by IRIS Registry–EHR integration
		Expanded Practice Access	
59	IA_EPA_1	Provide 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record	No EHR required
60	IA_EPA_6*	Create and implement a language access plan	No EHR required
		Patient Safety and Practice Assessment	
page 60	IA_PSPA_22	CDC training on CDC's guideline for prescribing opioids for chronic pain**	No EHR required
	IA_PSPA_23	Completion of CDC training on antibiotic stewardship**	No EHR required
	IA_PSPA_31	Patient medication risk education	No EHR required
	IA_PSPA_32	Use of CDC guideline for clinical decision support to prescribe opioids for chronic pain via clinical decision support	
		Population Management	
60	IA_PM_3	Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center (FQHC) quality improvement activities	No EHR required

* This improvement activity is a new option for IRIS Registry users.

** You can select IA_PSPA_22 only once every four years. The same is true for IA_PSPA_23.

MEDIUM-WEIGHTED ACTIVITIES			
	ID#	Improvement Activity	Notes
	Achieving Health Equity		
page 61	IA_AHE_5	MIPS eligible clinician leadership in clinical trials or CBPR [community-based participatory research]	No EHR required
	IA_AHE_7	Comprehensive eye exams	No EHR required
	IA_AHE_9*	Implement food insecurity and nutrition risk identification and treatment protocols	No EHR required
62	IA_AHE_10*	Adopt Certified Health Information Technology for security tags for EHR data	
	Beneficiary Engagement		
page 62	IA_BE_1	Use of certified EHR to capture patient reported outcomes	
	IA_BE_3	Engagement with QIN-QIO to implement self-management training programs [Quality Innovation Network-Quality Improvement Organization]	No EHR required
	IA_BE_4	Engagement of patient through implementation of improvements in patient portal	
	IA_BE_5	Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities	No EHR required
	IA_BE_12	Use evidence-based decision aids to support shared decision-making	No EHR required
	IA_BE_15	Engagement of patients, family, and caregivers in developing a plan of care	
63	IA_BE_16	Promote self-management in usual care	No EHR required
	Care Coordination		
page 63	IA_CC_1	Implementation of use of specialist reports back to referring clinician or group to close referral loop	No EHR required
	IA_CC_2	Implementation of improvements that contribute to more timely communication of test results	No EHR required
	IA_CC_7	Regular training in care coordination	No EHR required
	IA_CC_8	Implementation of documentation improvements for practice/process improvements	No EHR required
	IA_CC_9	Implementation of practices/processes for developing regular individual care plans	No EHR required
	IA_CC_12	Care coordination agreements that promote improvements in patient tracking across settings	No EHR required
64	IA_CC_13	Practice improvements to align with OpenNotes principles	Revised for 2023
	IA_CC_18	Relationship-centered communication	No EHR required
	Emergency Response and Preparedness		
page 64	IA_ERP_1	Participation on Disaster Medical Assistance Team, registered for six months	No EHR required
	IA_ERP_4*	Implementation of a personal protective equipment (PPE) plan	No EHR required
	IA_ERP_6*	COVID-19 vaccine achievement for practice staff	No EHR required

* This improvement activity is a new option for IRIS Registry users.

	Expanded Practice Access		
64	IA_EPA_2	Use of telehealth services that expand practice access	No EHR required
	IA_EPA_3	Collection and use of patient experience and satisfaction data on access	No EHR required
page 65	IA_EPA_4	Additional improvements in access as a result of QIN/QIO TA [Quality Innovation Network-Quality Improvement Organization technical assistance]	No EHR required
	IA_EPA_5	Participation in user testing of the Quality Payment Program website (https://qpp.cms.gov/)	No EHR required
	Patient Safety and Practice Assessment		
page 65	IA_PSPA_1	Participation in an AHRQ-listed patient safety organization	
	IA_PSPA_2	Participation in MOC Part IV	No EHR required; IRIS Registry –EHR integration required for Academy/ABO option
	IA_PSPA_4	Administration of the AHRQ Survey of Patient Safety Culture	No EHR required
	IA_PSPA_7	Use of QCDR data for ongoing practice assessment and improvements	Facilitated by IRIS Registry–EHR integration, revised for 2023
page 66	IA_PSPA_8	Use of patient safety tools	No EHR required
	IA_PSPA_9	Completion of the AMA STEPS Forward program	No EHR required
	IA_PSPA_12	Participation in private payer CPIA [clinical practice improvement activities]	No EHR required
	IA_PSPA_13	Participation in Joint Commission Evaluation Initiative	No EHR required
	IA_PSPA_15*	Implementation of an ASP [antimicrobial stewardship program]	No EHR required
page 67	IA_PSPA_16	Use of decision support and standardized treatment protocols	No EHR required
	IA_PSPA_17	Implementation of analytic capabilities to manage total cost of care for practice population	No EHR required
	IA_PSPA_18	Measurement and improvement [of quality] at the practice and panel level	No EHR required
	IA_PSPA_19	Implementation of formal quality improvement methods, practice changes, or other practice improvement processes	No EHR required, revised for 2023
page 68	IA_PSPA_21	Implementation of fall screening and assessment programs	No EHR required
	IA_PSPA_25	Cost display for laboratory and radiographic orders	No EHR required
	IA_PSPA_26	Communication of unscheduled visit for adverse drug event and nature of event	No EHR required
	IA_PSPA_28	Completion of an accredited safety or quality improvement program	No EHR required
	Population Management		
page 68	IA_PM_5	Engagement of community for health status improvement	No EHR required
	IA_PM_6	Use of toolsets or other resources to close healthcare disparities across communities	No EHR required
page 69	IA_PM_11	Regular review practices in place on targeted patient population needs	No EHR required
	IA_PM_17	Participation in population health research	No EHR required
	IA_PM_18*	Provide clinical-community linkages	No EHR required

* This improvement activity is a new option for IRIS Registry users.

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Table 8: Improvement Activity Descriptions

The IRIS Registry supports reporting of the 66 improvement activities that are most relevant to ophthalmology—18 of those are high-weighted (see below) and 48 are medium-weighted (see page 61).

Select your improvement activities carefully. To determine which improvement activities would be right for your practice, review the descriptions below and see the detailed specifications, including documentation suggestions, at aao.org/medicare/improvement-activities.

These descriptions are drawn from CMS materials. The descriptions below are based on CMS materials available at time of press, but you should check online for updates before performing your improvement activities.

Make sure your documentation includes dates. In case of a future audit, your documentation should show that an improvement activity was performed for the 90-day (or longer) performance period.

HIGH-WEIGHTED IMPROVEMENT ACTIVITIES

Achieving Health Equity

IA_AHE_1: Enhance engagement of Medicaid and other underserved populations

Scoring: High weighted.
Notes: No EHR required.
Description: To improve responsiveness of care for Medicaid and other underserved patients: use time-to-treat data (i.e., data measuring the time between clinician identifying a need for an appointment and the patient having a scheduled appointment) to identify patterns by which care or engagement with Medicaid patients or other groups of underserved patients has not achieved standard practice guidelines; and with this information, create, implement, and monitor an approach for improvement. This approach may include screening for patient barriers to treatment, especially transportation barriers, and providing resources to improve engagement (e.g., state Medicaid non-emergency medical transportation benefit).

IA_AHE_3: Promote use of patient-reported outcome tools

Scoring: High weighted.
Notes: No EHR required.
Description: Demonstrate performance of activities for employing patient-reported outcome (PRO) tools and corresponding collection of PRO data such as the use of PHQ-2 or PHQ-9, PROMIS instruments, patient-reported Wound-Quality of Life (QoL), patient-reported Wound Outcome, and patient-reported Nutritional Screening.

IA_AHE_6: Provide education opportunities for new clinicians

Scoring: High weighted.
Notes: No EHR required.
Description: MIPS eligible clinicians acting as a preceptor for clinicians-in-training (such as medical residents/fellows, medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved, or rural areas.
CMS note: CMS has said that "this activity is intended to support clinicians-in-training in community practices in small, underserved, or rural areas, not metropolitan areas."

IA_AHE_8: Create and implement an anti-racism plan

Scoring: High weighted.
Notes: No EHR required.
Description: Create and implement an anti-racism plan using the CMS Disparities Impact Statement or other anti-racism planning tools. The plan should include a clinic-wide review of existing tools and policies, such as value statements or clinical practice guidelines, to ensure that they include and are aligned with a commitment to anti-racism and an understanding of race as a political and social construct, not a physiological one. The plan should also identify ways in which issues and gaps identified in the review can be addressed and should include target goals and milestones for addressing prioritized issues and gaps. This may also include an assessment and drafting of an organization's plan to prevent and address racism and/or improve language access and accessibility to ensure services are accessible and understandable for those seeking care. The MIPS eligible clinician or practice can also consider including in their plan ongoing training on anti-racism and/or other processes to support identifying explicit and implicit biases in patient care and addressing historic health inequities experienced by people of color. More information about elements of the CMS Disparities Impact Statement is detailed in the template and action plan document at www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf.

IA_AHE_11: Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer patients

Scoring: High weighted.
Notes: No EHR required.
Description: Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care, collecting and using patients' pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories.

IA_AHE_12: Practice improvements that engage community resources to address drivers of health

Scoring: High weighted.
Notes: No EHR required.
Description: Select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools. If possible, use a screening tool that is health IT-enabled and includes standards-based, coded questions/fields for the capture of data. After screening, address identified drivers of health through at least one of the following:
• Develop and maintain formal relationships with community-based organizations to strengthen the community service referral process, implementing closed-loop referrals where feasible; or
• Work with community partners to provide and/or update a community resource guide for to patients who are found to have and/or be at risk in one or more areas of drivers of health; or
• Record findings of screening and follow up within the electronic health record (EHR); identify screened patients with one or more needs associated with drivers of health and implement approaches to better serve their holistic needs through meaningful linkages to community resources.

Drivers of health (also referred to as social determinants of health [SDOH] or health-related social needs [HSRN]) prioritized by the practice might include, but are not limited to, the following: food security; housing stability; transportation accessibility; interpersonal safety; legal challenges; and environmental exposures.

Beneficiary Engagement

IA_BE_6: Regularly assess patient experience of care and follow up on findings

Scoring: High weighted.
Notes: No EHR required.
Description: Collect and follow-up on patient experience and satisfaction data. This activity also requires follow-up on findings of assessments, including the development and implementation of improvement plans. To fulfill the requirements of this activity, MIPS eligible clinicians can use surveys (e.g., Consumer Assessment of Healthcare Providers and Systems Survey), advisory councils, or other mechanisms. MIPS eligible clinicians may consider implementing patient surveys in multiple languages, based on the needs of their patient population.

IA_BE_14: Engage patients and families to guide improvement in the system of care

Scoring: High weighted.
Notes: No EHR required.
Description: Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement.

Platforms and devices that collect patient-generated health data (PGHD) must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient-reported outcomes (PROs).

Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams.

Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g., automated patient-facing instructions based on glucometer readings).

Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and plat-

forms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient's status, adherence, comprehension, and indicators of clinical concern.

IA_BE_25: Drug cost transparency

Scoring: High weighted.
Notes: No EHR required.
Description: Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT) which provides to the prescriber real-time patient-specific formulary and benefit information for drugs, including cost-sharing for a beneficiary.

Emergency Response and Preparedness

IA_ERP_2: Participation in a 60-day or greater effort to support domestic or international humanitarian needs

Scoring: High weighted.
Notes: No EHR required.
Description: Participation in domestic or international humanitarian volunteer work. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and groups attest to domestic or international humanitarian volunteer work for a period of a continuous 60 days or greater.

IA_ERP_3: COVID-19 clinical data reporting with or without clinical trial

Scoring: High weighted.
Notes: Facilitated by IRIS Registry–EHR integration. The goal of this improvement activity is to support innovation and improve the collection of COVID-19–related data that clinicians have available to them and to develop best practices that can drive improvements in patient care.
Description: To receive credit for this improvement activity, a MIPS eligible clinician or group must:
1) participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or
2) participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research. Data would be submitted to the extent permitted by applicable privacy and security laws.

Examples of COVID-19 clinical trials may be found on the U.S. National Library of Medicine website at https://clinicaltrials.gov/ct2/results?cond=COVID-19. In addition, examples of COVID-19 clinical data registries may be found on the National Institute of Health website at https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=COVID19+registries&commit=Search.

For purposes of this improvement activity, clinical data registries must meet the following requirements: 1) the receiving entity must declare that they are ready to accept data as a clinical registry; and 2) be using the data to improve population health outcomes. Most public health agencies and clinical data registries declare readiness to accept data from clinicians via a public online posting. Clinical data registries should make publically available specific information on what data the registry gathers, technical requirements or specifications for how the registry can receive the data, and how the registry may use, re-use, or disclose individually identifiable data it receives. For purposes of credit toward this improvement activity, any data should be sent to the clinical data registry in a structured format, which the registry is capable of receiving. A MIPS-eligible clinician may submit the data using any standard or format that is supported by the clinician's health IT systems, including but not limited to, certified functions within those systems. Such methods may include, but are not limited to, a secure upload function on a web portal, or submission via an intermediary, such as a health information exchange. To ensure interoperability and versatility of the data submitted, any electronic data should be submitted to the clinical data registry using appropriate vocabulary standards for the specific data elements, such as those identified in the United States Core Data for Interoperability (USCDI) standard adopted in 45 CFR 170.213.

Expanded Practice Access

IA_EPA_1: Provide 24/7 access to MIPS eligible clinicians or groups who have real-time access to patient's medical record

Scoring: High weighted.
Notes: No EHR required.
Description: Provide 24/7 access to MIPS eligible clinicians, groups, or care teams for advice about urgent care (e.g., MIPS eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following:

- Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care);
- Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or

• Provision of same-day or next-day access to a MIPS eligible clinician, group or care team when needed for urgent care or transition management.

IA_EPA_6: Create and implement a language access plan

Scoring: High weighted.
Notes: No EHR required.
Description: Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).

Patient Safety and Practice Assessment

IA_PSPA_22: CDC training on CDC's guideline for prescribing opioids for chronic pain

Scoring: High weighted.
Notes: No EHR required.
Description: Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain."
CMS note: This activity may be selected once every four years, to avoid duplicative information given that some of the modules may change on a year by year basis but over four years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.

IA_PSPA_23: Completion of CDC training on antibiotic stewardship

Scoring: High weighted.
Notes: No EHR required.
Description: Completion of all modules of the Centers for Disease Control and Prevention antibiotic stewardship course.
CMS note: This activity may be selected once every four years, to avoid duplicative information given that some of the modules may change on a year by year basis but over four years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.

IA_PSPA_31: Patient medication risk education

Scoring: High weighted.
Notes: No EHR required.
Description: In order to receive credit for this activity, MIPS eligible clinicians must provide both written and verbal education regarding the risks of concurrent opioid and benzodiazepine use for patients who are prescribed both benzodiazepines and opioids. Education must be completed for at least 75% of qualifying patients and occur: 1) at the time of initial co-prescribing and again following greater than six months of co-prescribing of benzodiazepines and opioids, or 2) at least once per MIPS performance period for patients taking concurrent opioid and benzodiazepine therapy.

IA_PSPA_32: Use of CDC guideline for clinical decision support to prescribe opioids for chronic pain via clinical decision support

Scoring: High weighted.
Notes: May include EHR-based prescribing prompts.
Description: In order to receive credit for this activity, MIPS eligible clinicians must utilize the Centers for Disease Control (CDC) Guideline for Prescribing Opioids for Chronic Pain via clinical decision support (CDS). For CDS to be most effective, it needs to be built directly into the clinician workflow and support decision-making on a specific patient at the point of care. Specific examples of how the guideline could be incorporated into a CDS workflow include, but are not limited to: electronic health record (EHR)–based prescribing prompts, order sets that require review of guidelines before prescriptions can be entered, and prompts requiring review of guidelines before a subsequent action can be taken in the record.
CMS note: CDC Clinical Practice Guideline for Prescribing Opioids for Pain: www.cdc.gov/drugoverdose/prescribing/guideline.html; please note that this guideline was updated in November 2022 (www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm). This guideline/CDS may be updated periodically, and the most recent available guideline/CDS should be referred to/used in completing this activity.

Population Management

IA_PM_3: Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center (FQHC) quality improvement activities

Scoring: High weighted.
Notes: No EHR required.
Description: Participating in a Rural Health Clinic (RHC), Indian Health Service Medium Management (IHS), or Federally Qualified Health Center (FQHC) in ongoing engagement activities that contribute to more formal

quality reporting, and that include receiving quality data back for broader quality improvement and benchmarking improvement which will ultimately benefit patients. Participation in Indian Health Service, as an improvement activity, requires MIPS eligible clinicians and groups to deliver care to federally recognized American Indian and Alaska Native populations in the United States and in the course of that care implement continuous clinical practice improvement including reporting data on quality of services being provided and receiving feedback to make improvements over time.

MEDIUM-WEIGHTED IMPROVEMENT ACTIVITIES

Achieving Health Equity

IA_AHE_5: MIPS eligible clinician leadership in clinical trials or CBPR [community-based participatory research]

Scoring: Medium weighted.
Notes: No EHR required.
Description: Lead clinical trials, research alliances, or community-based participatory research (CBPR) that identify tools, research, or processes that focus on minimizing disparities in healthcare access, care quality, affordability, or outcomes. Research could include addressing health-related social needs like food insecurity, housing insecurity, transportation barriers, utility needs, and interpersonal safety.

IA_AHE_7: Comprehensive eye exams

Scoring: Medium weighted.
Notes: No EHR required.
Description: To receive credit for this activity, MIPS eligible clinicians must promote the importance of a comprehensive eye exam, which may be accomplished by any one or more of the following:

- providing literature,
- facilitating a conversation about this topic using resources such as the "Think About Your Eyes" campaign,
- referring patients to resources providing no-cost eye exams, such as the American Academy of Ophthalmology's EyeCare America and the American Optometric Association's VISION USA, or
- promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment.

This activity is intended for:
1) non-ophthalmologists/optometrists who refer patients to an ophthalmologist/optometrist;
2) ophthalmologists/optometrists caring for underserved patients at no cost; or
3) any clinician providing literature and/or resources on this topic.

This activity must be targeted at underserved and/or high-risk populations that would benefit from engagement regarding their eye health with the aim of improving their access to comprehensive eye exams or vision rehabilitation services.

Help ECA: The Academy's EyeCare America program helps seniors who have not had a medical eye exam in three or more years, and people who are at increased risk for glaucoma, get access to eye care. You can make a big difference in the lives of these patients with a minimal time commitment and without leaving your office. To find out how it works, visit aao.org/volunteer.

IA_AHE_9: Implement food insecurity and nutrition risk identification and treatment protocols

Scoring: Medium weighted.
Notes: No EHR required.
Description: Create or improve, and then implement, protocols for identifying and providing appropriate support to: a) patients with or at risk for food insecurity, and b) patients with or at risk for poor nutritional status. (Poor nutritional status is sometimes referred to as clinical malnutrition or undernutrition and applies to people who are overweight and underweight.) Actions to implement this improvement activity may include, but are not limited to, the following:

- Use Malnutrition Quality Improvement Initiative (MQii) or other quality improvement resources and standardized screening tools to assess and improve current food insecurity and nutritional screening and care practices.
- Update and use clinical decision support tools within the MIPS eligible clinician's electronic medical record to align with the new food insecurity and nutrition risk protocols.
- Update and apply requirements for staff training on food security and nutrition.
- Update and provide resources and referral lists, and/or engage with community partners to facilitate referrals for patients who are identified as at risk for food insecurity or poor nutritional status during screening.

Activities must be focused on patients at greatest risk for food insecurity and/or malnutrition—for example patients with low income who live in areas with limited access to affordable fresh food, or who are isolated or have limited mobility.
Tip: For a discussion about addressing food insecurity, see "Ophthalmology's Challenge: Tackling Social Determinants of Health" (September 2022, *EyeNet*) at aao.org/eyenet/archive.

IA_AHE_10: Adopt Certified Health Information Technology for security tags for electronic health record data

Scoring: Medium weighted.
Notes: This activity involves use of an EHR system's security labeling services.
Description: Use security labeling services available in certified Health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation. Certification criteria for security tags may be found in the ONC Health IT Certification Program at 45 CFR 170.315(b)(7) and (b)(8).

Beneficiary Engagement

IA_BE_1: Use of certified EHR to capture patient reported outcomes

Scoring: Medium weighted.
Notes:
Description: To improve patient access, perform activities beyond routine care that enable capture of patient reported outcomes (for example, related to functional status, symptoms and symptom burden, health behaviors, or patient experience) or patient activation measures (that is, measures of patient involvement in their care) through use of certified electronic health record technology, and record these outcomes data for clinician review.

IA_BE_3: Engagement with QIN-QIO to implement self-management training programs [Quality Innovation Network-Quality Improvement Organization]

Scoring: Medium weighted.
Notes: No EHR required.
Description: Engagement with a Quality Innovation Network-Quality Improvement Organization, which may include participation in self-management training programs such as diabetes.

IA_BE_4: Engagement of patients through implementation of improvements in patient portal

Scoring: Medium weighted.
Notes:
Description: To receive credit for this activity, MIPS eligible clinicians must provide access to an enhanced patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange. The primary use of this portal should be clinical and not administrative.

Examples of the use of such a portal include, but are not limited to: brief patient reevaluation by messaging; communication about test results and follow-up; communication about medication adherence, side effects, and refills; blood pressure management for a patient with hypertension; blood sugar management for a patient with diabetes; or any relevant acute or chronic disease management.

IA_BE_5: Enhancements/regular updates to practice websites/tools that also include considerations for patients with cognitive disabilities

Scoring: Medium weighted.
Notes: No EHR required.
Description: Enhancements and ongoing regular updates and use of websites/tools that include consideration for compliance with section 508 of the Rehabilitation Act of 1973 or for improved design for patients with cognitive disabilities. Refer to the CMS website on Section 508 of the Rehabilitation Act (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/Section508/index.html?redirect=/InfoTech GenInfo/07_Section508.asp) that requires that institutions receiving federal funds solicit, procure, maintain and use all electronic and information technology (EIT) so that equal or alternate/comparable access is given to members of the public with and without disabilities. For example, this includes designing a patient portal or website that is compliant with section 508 of the Rehabilitation Act of 1973.
CMS note: Find 508 compliance information at www.section508.gov.

IA_BE_12: Use evidence-based decision aids to support shared decision-making

Scoring: Medium weighted.
Notes: No EHR required.
Description: Use evidence-based decision aids to support shared decision-making.

IA_BE_15: Engagement of patients, family, and caregivers in developing a plan of care

Scoring: Medium weighted.
Notes: CMS says that you can use an "electronic platform to systematically capture patient preferences/value through validated patient experience measure instrument."
Description: Engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the electronic health record (EHR) technology.

IA_BE_16: Promote self-management in usual care

Scoring: Medium weighted.
Notes: No EHR required.
Description: To help patients self-manage their care, incorporate culturally and linguistically tailored evidence-based techniques for promoting self-management into usual care, and provide patients with tools and resources for self-management. Examples of evidence-based techniques to use in usual care include: goal setting with structured follow-up, Teach-back methods, action planning, assessment of need for self-management (for example, the Patient Activation Measure), and motivational interviewing. Examples of tools and resources to provide patients directly or through community organizations include: peer-led support for self-management, condition-specific chronic disease or substance use disorder self-management programs, and self-management materials.

Care Coordination

IA_CC_1: Implementation of use of specialist reports back to referring clinician or group to close referral loop

Scoring: Medium weighted.
Notes: No EHR required.
Description: Performance of regular practices that include providing specialist reports back to the referring individual MIPS eligible clinician or group to close the referral loop or where the referring individual MIPS eligible clinician or group initiates regular inquiries to specialist for specialist reports which could be documented or noted in the EHR technology.
Academy tip: This improvement activity involves regularly taking certain actions when you are receiving the referral and when you are the referring clinician:
• When you receive referrals, provide specialist reports back to the MIPS-eligible clinician or group to close the referral loop.
• When you are referring, initiate regular inquiries to the specialist for specialist reports that could be documented or noted in the EHR.

IA_CC_2: Implementation of improvements that contribute to more timely communication of test results

Scoring: Medium weighted.
Notes: No EHR required.
Description: Timely communication of test results defined as timely identification of abnormal test results with timely follow-up.

IA_CC_7: Regular training in care coordination

Scoring: Medium weighted.
Notes: No EHR required.
Description: Implementation of regular care coordination training.
CMS note: Utilize preferred practice patterns within your practice to improve care coordination. Document evidence of regular care coordination training. Evidence could include, for example, training curriculum/materials and attendance or training certification registers/documents.

IA_CC_8: Implementation of documentation improvements for practice/process improvements

Scoring: Medium weighted.
Notes: No EHR required.
Description: Implementation of practices/processes that document care coordination activities (e.g., a documented care coordination encounter that tracks all clinical staff involved and communications from date patient is scheduled for outpatient procedure through day of procedure).

IA_CC_9: Implementation of practices/processes for developing regular individual care plans

Scoring: Medium weighted.
Notes: No EHR required.
Description: Implementation of practices/processes, including a discussion on care, to develop regularly updated individual care plans for at-risk patients that are shared with the beneficiary or caregiver(s). Individual care plans should include consideration of a patient's goals and priorities, as well as desired outcomes of care.

IA_CC_12: Care coordination agreements that promote improvements in patient tracking across settings

Scoring: Medium weighted.
Notes: No EHR required.
Description: Establish effective care coordination and active referral management that could include one or more of the following:
• Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and MIPS eligible clinician or MIPS eligible clinician group expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements;
• Track patients referred to specialist through the entire process; and/or
• Systematically integrate information from referrals into the plan of care.

IA_CC_13: Practice improvements to align with OpenNotes principles

Scoring: Medium weighted.
Notes: Activity name and description updated for 2023. For information on OpenNotes, read "The OpenNotes Movement—Why Clinicians Are Sharing Notes With Patients" (*EyeNet*, June 2016) at aao.org/eyenet/archive.
Description: Adherence to the principles described in the OpenNotes initiative (https://www.opennotes.org) to ensure that patients have full access to their patient information to guide patient care.

IA_CC_18: Relationship-centered communication

Scoring: Medium weighted.
Notes: No EHR required.
Description: In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans, monitor progress, and promote stability around improved clinician communication.

Emergency Response and Preparedness

IA_ERP_1: Participation on Disaster Medical Assistance Team, registered for six months

Scoring: Medium weighted.
Notes: No EHR required.
Description: Participation in Disaster Medical Assistance Teams, or Community Emergency Responder Teams. Activities that simply involve registration are not sufficient. MIPS eligible clinicians and MIPS eligible clinician groups must be registered for a minimum of six months as a volunteer for disaster or emergency response.

IA_ERP_4: Implementation of a personal protective equipment (PPE) plan

Scoring: Medium weighted.
Notes: No EHR required.
Description: Implement a plan to acquire, store, maintain, and replenish supplies of personal protective equipment (PPE) for all clinicians or other staff who are in physical proximity to patients. In accordance with guidance from the Centers for Disease Control and Prevention (CDC) the PPE plan should address:
• Conventional capacity: PPE controls that should be implemented in general infection prevention and control plans in healthcare settings, including training in proper PPE use.
• Contingency capacity: actions that may be used temporarily during periods of expected PPE shortages.
• Crisis capacity: strategies that may need to be considered during periods of known PPE shortages. The PPE plan should address all of the following types of PPE:
• Standard precautions (e.g., hand hygiene, prevention of needle-stick or sharps injuries, safe waste management, cleaning and disinfection of the environment)
• Eye protection
• Gowns (including coveralls or aprons)
• Gloves
• Facemasks
• Respirators (including N95 respirators)

IA_ERP_6: COVID-19 vaccine achievement for practice staff

Scoring: Medium weighted.
Notes: No EHR required.
Description: Demonstrate that the MIPS eligible clinician's practice has maintained or achieved a rate of 100% of office staff staying up to date with COVID vaccines according to the Centers for Disease Control and Prevention (www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html). Please note that those who are determined to have a medical contraindication specified by CDC recommendations are excluded from this activity.

Expanded Practice Access

IA_EPA_2: Use of telehealth services that expand practice access

Scoring: Medium weighted.
Notes: No EHR required.
Description: Create and implement a standardized process for providing telehealth services to expand access to care.
CMS note: For the purposes of this improvement activity, telehealth services include a "real time" interaction and may be obtained over the phone, online, etc., and are not limited to the Medicare reimbursed telehealth service criteria. For telehealth tips, see https://telehealth.hhs.gov.

IA_EPA_3: Collection and use of patient experience and satisfaction data on access

Scoring: Medium weighted.
Notes: No EHR required.
Description: Collection of patient experience and satisfaction data on access to care and development of an

improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs.

Academy tip: Make sure the survey results include dates for each administered survey.

IA_EPA_4: Additional improvements in access as a result of QIN-QIO TA [Quality Innovation Network–Quality Improvement Organization technical assistance]

Scoring: Medium weighted.
Notes: No EHR required.
Description: As a result of Quality Innovation Network–Quality Improvement Organization technical assistance, performance of additional activities that improve access to services or improve care coordination (for example, investment of on-site diabetes educator).

IA_EPA_5: Participation in user testing of the Quality Payment Program website (https://qpp.cms.gov/)

Scoring: Medium weighted.
Notes: No EHR required.
Description: User participation in the Quality Payment Program website testing is an activity for eligible clinicians who have worked with CMS to provide substantive, timely, and responsive input to improve the CMS Quality Payment Program website through product user-testing that enhances system and program accessibility, readability and responsiveness as well as providing feedback for developing tools and guidance thereby allowing for a more user-friendly and accessible clinician and practice Quality Payment Program website experience.

Patient Safety and Practice Assessment

IA_PSPA_1: Participation in an AHRQ-listed patient safety organization

Scoring: Medium weighted.
Notes:
Description: Participation in an AHRQ-listed patient safety organization.
CMS note: To see which patient safety organizations (PSO) are listed by the Agency for Healthcare Research and Quality, visit www.pso.ahrq.gov/listed. Information on how to choose a PSO can be found at https://pso.ahrq.gov/work-with/choose.

IA_PSPA_2: Participation in MOC Part IV

Scoring: Medium weighted.
Notes: While there are options for performing this improvement activity without EHR, you can implement the Academy/ABO option only if you have an EHR system that has been integrated with the IRIS Registry. For more information, see https://abop.org/IRIS.
Description: In order to receive credit for this activity, a MIPS eligible clinician must participate in Maintenance of Certification (MOC) Part IV. Maintenance of Certification (MOC) Part IV requires clinicians to perform monthly activities across practice to regularly assess performance by reviewing outcomes addressing identified areas for improvement and evaluating the results.

Some examples of activities that can be completed to receive MOC Part IV credit are: the American Board of Internal Medicine (ABIM) Approved Quality Improvement (AQI) Program, National Cardiovascular Data Registry (NCDR) Clinical Quality Coach, Quality Practice Initiative Certification Program, American Board of Medical Specialties Practice Performance Improvement Module or American Society of Anesthesiologists (ASA) Simulation Education Network, for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program; specialty-specific activities including Safety Certification in Outpatient Practice Excellence (SCOPE); American Psychiatric Association (APA) Performance in Practice modules.

IA_PSPA_4: Administration of the AHRQ Survey of Patient Safety Culture

Scoring: Medium weighted.
Notes: No EHR required.
Description: Administration of the Agency for Healthcare Research and Quality (AHRQ) Survey of Patient Safety Culture and submission of data to the comparative database (refer to AHRQ Survey of Patient Safety Culture website http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html).
CMS note: This activity may be selected once every four years, to avoid duplicative information given that some of the modules may change on a year by year basis but over four years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.

IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements

Scoring: Medium weighted.
Notes: For 2023, CMS absorbed three other QCDR-based improvement activities into this one activity and expanded its description accordingly. IRIS Registry–EHR integration facilitates performance of this improvement activity.
Description: Participation in a qualified clinical data registry (QCDR) and use of QCDR data for ongoing

practice assessment and improvements in patient safety, including:
• Performance of activities that promote use of standard practices, tools and processes for quality improvement (for example, documented preventative screening and vaccinations that can be shared across MIPS eligible clinician or groups);
• Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment);
• Use of standardized processes for screening for drivers of health, such as food security, housing stability, and transportation accessibility;
• Generation and use of regular feedback reports that summarize local practice patterns and treatment outcomes, including for populations that are disadvantaged and/or underserved by the healthcare system;
• Use of processes and tools that engage patients to improve adherence to treatment plans;
• Implementation of patient self-action plans;
• Implementation of shared clinical decision-making capabilities;
• Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement;
• Promotion of collaborative learning network opportunities that are interactive;
• Use of supporting QCDR modules that can be incorporated into the certified EHR technology; or
• Use of QCDR data for quality improvement, such as comparative analysis across specific patient populations of adverse outcomes after an outpatient surgical procedure and corrective steps to address these outcomes.

IA_PSPA_8: Use of patient safety tools

Scoring: Medium weighted.
Notes: No EHR required.
Description: In order to receive credit for this activity, a MIPS eligible clinician must use tools that assist specialty practices in tracking specific measures that are meaningful to their practice.

Some examples of tools that could satisfy this activity are: a surgical risk calculator; evidence based protocols, such as Enhanced Recovery After Surgery (ERAS) protocols; the Centers for Disease Control (CDC) Guide for Infection Prevention for Outpatient Settings predictive algorithms; and the opiate risk tool (ORT) or similar tool.

IA_PSPA_9: Completion of the AMA STEPS Forward program

Scoring: Medium weighted.
Notes: No EHR required.
Description: Completion of the American Medical Association's STEPS Forward program [https://edhub.ama-assn.org/steps-forward].

IA_PSPA_12: Participation in private payer CPIA [clinical practice improvement activities]

Scoring: Medium weighted.
Notes: No EHR required.
Description: Participation in designated private payer clinical practice improvement activities.

IA_PSPA_13: Participation in Joint Commission Evaluation Initiative

Scoring: Medium weighted.
Notes: No EHR required.
Description: Participation in Joint Commission Ongoing Professional Practice Evaluation initiative.

IA_PSPA_15: Implementation of an antimicrobial stewardship program (ASP)

Scoring: Medium weighted.
Notes: No EHR required.
Description: Leadership of an Antimicrobial Stewardship Program (ASP) that includes implementation of an ASP that measures the appropriate use of antibiotics for several different conditions (such as but not limited to upper respiratory infection treatment in children, diagnosis of pharyngitis, bronchitis treatment in adults) according to clinical guidelines for diagnostics and therapeutics. Specific activities may include:
• Develop facility-specific antibiogram and prepare report of findings with specific action plan that aligns with overall facility or practice strategic plan.
• Lead the development, implementation, and monitoring of patient care and patient safety protocols for the delivery of ASP including protocols pertaining to the most appropriate setting for such services (i.e., outpatient or inpatient).
• Assist in improving ASP service line efficiency and effectiveness by evaluating and recommending improvements in the management structure and workflow of ASP processes.
• Manage compliance of the ASP policies and assist with implementation of corrective actions in accordance with facility or clinic compliance policies and hospital medical staff by-laws.
• Lead the education and training of professional support staff for the purpose of maintaining an efficient and effective ASP.
• Coordinate communications between ASP management and facility or practice personnel regarding activities, services, and operational/clinical protocols to achieve overall compliance and understanding of the ASP.
• Assist, at the request of the facility or practice, in preparing for and responding to third-party requests,

including but not limited to payer audits, governmental inquiries, and professional inquiries that pertain to the ASP service line.
• Implementing and tracking an evidence-based policy or practice aimed at improving antibiotic prescribing practices for high-priority conditions.
• Developing and implementing evidence-based protocols and decision-support for diagnosis and treatment of common infections.
• Implementing evidence-based protocols that align with recommendations in the Centers for Disease Control and Prevention's Core Elements of Outpatient Antibiotic Stewardship guidance.

IA_PSPA_16: Use of decision support and standardized treatment protocols

Scoring: Medium weighted.
Notes:
Description: Use decision support and standardized treatment protocols to manage workflow in the team to meet patient needs.

IA_PSPA_17: Implementation of analytic capabilities to manage total cost of care for practice population

Scoring: Medium weighted.
Notes: No EHR required.
Description: In order to receive credit for this activity, a MIPS eligible clinician must conduct or build the capacity to conduct analytic activities to manage total cost of care for the practice population. Examples of these activities could include:
1. Train appropriate staff on interpretation of cost and utilization information;
2. Use available data regularly to analyze opportunities to reduce cost through improved care.

An example of a platform with the necessary analytic capability to do this is the American Society for Gastrointestinal (GI) Endoscopy's GI Operations Benchmarking Platform.

IA_PSPA_18: Measurement and improvement [of quality] at the practice and panel level

Scoring: Medium weighted.
Notes: No EHR required.
Description: Measure and improve quality at the practice and panel level, such as the American Board of Orthopaedic Surgery (ABOS) Physician Scorecards, that could include one or more of the following:
• Regularly review measures of quality, utilization, patient satisfaction and other measures; and/or
• Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.

MIPS eligible clinicians can apply the measurement and quality improvement to address inequities in quality and outcomes for underserved populations, including racial, ethnic, and/or gender minorities.
CMS note: Surveys should be administered by a third-party survey administrator/vendor.

IA_PSPA_19: Implementation of formal quality improvement methods, practice changes, or other practice improvement processes

Scoring: Medium weighted.
Notes: For 2023, the description was updated to indicate that the leadership of the practice should be involved in this activity. No EHR required.
Description: Adopt a formal model for quality improvement and create a culture in which all staff, including leadership, actively participates in improvement activities that could include one or more of the following, such as:
• Participation in multisource feedback;
• Train all staff in quality improvement methods;
• Integrate practice change/quality improvement into staff duties;
• Engage all staff in identifying and testing practices changes;
• Designate regular team meetings to review data and plan improvement cycles;
• Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff;
• Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data;
• Participation in Bridges to Excellence;
• Participation in American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.

IA_PSPA_21: Implementation of fall screening and assessment programs

Scoring: Medium weighted
Notes: No EHR required.
Description: Implementation of fall screening and assessment programs to identify patients at risk for falls and address modifiable risk factors (e.g., clinical decision support/prompts in the electronic health record that help manage the use of medications, such as benzodiazepines, that increase fall risk).

IA_PSPA_25: Cost display for laboratory and radiographic orders

Scoring: Medium weighted.
Notes: No EHR required.
Description: Implementation of a cost display for laboratory and radiographic orders, such as costs that can be obtained through the Medicare clinical laboratory fee schedule.

IA_PSPA_26: Communication of unscheduled visit for adverse drug event and nature of event

Scoring: Medium weighted.
Notes: No EHR required.
Description: A MIPS eligible clinician providing unscheduled care (such as an emergency room, urgent care, or other unplanned encounter) attests that, for greater than 75% of case visits that result from a clinically significant adverse drug event, the MIPS eligible clinician provides information, including through the use of health IT to the patient's primary care clinician regarding both the unscheduled visit and the nature of the adverse drug event within 48 hours. A clinically significant adverse event is defined as a medication-related harm or injury such as side effects, supratherapeutic effects, allergic reactions, laboratory abnormalities, or medication errors requiring urgent/emergent evaluation, treatment, or hospitalization.

IA_PSPA_28: Completion of an accredited safety or quality improvement program

Scoring: Medium weighted.
Notes: No EHR required.
Description: Completion of an accredited performance improvement continuing medical education (CME) program that addresses performance or quality improvement according to the following criteria:
• The activity must address a quality or safety gap that is supported by a needs assessment or problem analysis, or must support the completion of such a needs assessment as part of the activity;
• The activity must have specific, measurable aim(s) for improvement;
• The activity must include interventions intended to result in improvement;
• The activity must include data collection and analysis of performance data to assess the impact of the interventions; and
• The accredited program must define meaningful clinician participation in their activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.

An example of an activity that could satisfy this improvement activity is completion of an accredited continuing medical education program related to opioid analgesic risk and evaluation strategy (REMS) to address pain control (that is, acute and chronic pain).

Population Management

IA_PM_5: Engagement of community for health status improvement

Scoring: Medium weighted.
Notes: No EHR required.
Description: Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidenced-based practices to improve a specific chronic condition. Refer to the local Quality Improvement Organization (QIO) for additional steps to take for improving health status of communities as there are many steps to select from for satisfying this activity. QIOs work under the direction of CMS to assist MIPS eligible clinicians and groups with quality improvement, and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund.
Academy tip: To locate your local QIO, visit https://qioprogram.org/locate-your-qio.

IA_PM_6: Use of toolsets or other resources to close healthcare disparities across communities

Scoring: Medium weighted.
Notes: No EHR required.
Description: Address inequities in health outcomes by using population health data analysis tools to identify health inequities in the community and practice and assess options for effective and relevant interventions such as Population Health Toolkit or other resources identified by the clinician, practice, or by CMS. Based on this information, create, refine, and implement an action plan to address and close inequities in health outcomes and/or health care access, quality, and safety.

IA_PM_11: Regular review practices in place on targeted patient population needs

Scoring: Medium weighted.
Notes: No EHR required.
Description: Implement regular reviews of targeted patient population needs, such as structured clinical case reviews, which include access to reports that show unique characteristics of MIPS eligible clinician's patient population, identification of underserved patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources. The review should consider how structural inequities, such as racism, are influencing patterns of care and consider changes to acknowledge and address them. Reviews should stratify patient data by demographic characteristics and health related social needs to appropriately identify differences among unique populations and assess the drivers of gaps and disparities and identify interventions appropriate for the needs of the sub-populations.

IA_PM_17: Participation in population health research

Scoring: Medium weighted.
Notes: No EHR required.
Description: Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population.

IA_PM_18: Provide clinical-community linkages

Scoring: Medium weighted.
Notes: No EHR required.
Description: Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.

NO REPORTING NEEDED FOR THIS PERFORMANCE CATEGORY

How CMS Evaluates Cost

Cost is the only one of the four performance categories where you don't report data or make attestations. Instead, CMS will use administrative claims data to evaluate performance. Cost's default weight in your MIPS final score is now 30%, meaning that it can contribute up to 30 points to that score.

Many Cost Measures in 2023

This year, cost measures include:

- the Total Per Capita Cost (TPCC) measure,
- the Medicare Spending Per Beneficiary measure, and
- 23 episode-based measures, including one for routine cataract surgery and another for melanoma resection.

Only one or two cost measures are likely to apply to ophthalmologists. As an ophthalmologist, you may be scored on the cataract surgery measure. Also, some oculofacial specialists may be scored on the melanoma measure. However, the other 21 episode-based cost measures don't apply to ophthalmology; the TPCC measure explicitly excludes ophthalmologists and optometrists; and the Medicare Spending Per Beneficiary measure focuses on inpatient hospitalization costs.

Performance period is the full calendar year. When CMS evaluates you on cost, it will include the cost of items and services that were provided from Jan. 1, 2023, to Dec. 31, 2023.

What if you don't get a cost score? If you don't meet the case minimum for the cataract surgery measure, and assuming you aren't scored on any of the other cost measures, cost's contribution to your MIPS final score will be reweighted to 0%, and one or more other performance categories will be reweighted upward (see Table 3, page 14).

Cost 101

Default weight in MIPS final score: 30%.

Performance period: Full calendar year.

Won't apply to all ophthalmologists: You are not likely to be scored on cost unless you perform cataract surgery and/or perform melanoma resection and/or are in a multispecialty practice that reports as a group. If you are not scored on cost, its weight is reallocated as shown in Table 3 (page 14).

No reporting requirements: CMS evaluates clinicians' cost score based on Medicare claims data for patients that it attributes to them.

Total Per Capita Cost Measure

This measure tries to allocate all of a patient's Medicare Part A and Part B costs to a primary care clinician. However, if the patient doesn't see such a clinician, he or she could be attributed to a non–primary care clinician.

Ophthalmologists and optometrists are excluded from the TPCC measure. In years gone by, some ophthalmologists were scored on the TPCC measure, and some eye care practices decided to bill Eye visit codes rather than Evaluation and Management (E/M) codes in order to avoid meeting the 20-patient case minimum for this measure. Since 2020, ophthalmologists and optometrists are excluded from this measure based on their two-digit specialty identifier in the Provider Enrollment, Chain, and Ownership System, better known as PECOS.

Caveat. Suppose you are in a multispecialty practice and you have colleagues who aren't excluded from the TPCC measure; if the practice reports as a group, the group may be scored on this measure.

Medicare Spending Per Beneficiary Measure

The Medicare Spending Per Beneficiary (MSPB) measure focuses on costs associated with hospital admission.

The MSPB measure is unlikely to factor into your MIPS score. Episodes of care are attributed to the MIPS eligible clinician who provided the most Medicare Part B covered services during the hospitalization. You will receive a score for the MSPB measure only in the unlikely event that at least 35 hospitalization episodes are attributed to you.

Episode-Based Measures

For each episode-based cost measure, CMS will use Medicare claims data to 1) attribute relevant procedures to you and 2) track costs that are clinically associated with those procedures. The following two episode-based measures might apply to ophthalmologists:

- Routine Cataract Removal With IOL Implantation
- Melanoma Resection

Which procedures are attributed to you? An episode of routine cataract surgery or melanoma resection will be attributed to the MIPS eligible clinician who performed

the procedure that "triggers" the episode. That procedure is known as the "trigger service," and the date it took place is the "trigger day." For the cataract measure, if you bill CPT code 66984—which is the code for routine cataract surgery—an episode of cataract surgery will be attributed to you unless an exclusion applies. (Note: Billing CPT code 66982 for complex cataract surgery would not trigger an episode.)

For the melanoma measure, CMS looks for CPT codes that indicate melanoma resection by removal of malignant growth; by adjacent tissue transfer or rearrangement procedures; or by repair of wounds using tissue transfer—but such CPT codes would only trigger an episode if accompanied by ICD-10 code C43 (malignant melanoma of skin) or D03 (melanoma in situ).

Exclusions. For the cataract surgery measure, exclusions include significant ocular conditions, such as a retinal detachment, that might impact the outcome of the surgery. For the melanoma measure, exclusions include any patient who undergoes Mohs surgery at any time during a procedure's five-month review period (see "What costs are included," below). CMS reviews the patient's Medicare claims history to see if there were any ICD-10 diagnosis codes that would flag such exclusions.

A 10-episode case minimum. The cataract measure will only contribute to your cost score if at least 10 episodes of routine cataract surgery are attributed to you in 2023. The melanoma measure also has a 10-episode case minimum.

What costs are included? These cost measures take into account only the cost of services that are clinically related to the cataract surgery or melanoma resection. CMS identifies those costs by reviewing the patient's Medicare claims over a five-month period. For the cataract and melanoma measures, this review period—also known as the episode window—starts 60 days before the day of surgery (the trigger day) and ends 90 days after surgery (mirroring the familiar 90-day postoperative period).

CMS tries to level the playing field. Your costs for the measure will undergo payment standardization and risk adjustment. This is intended to account for cost variations that are beyond your control, such as patient characteristics that may lead to increased spending and geographic variations in wage levels.

Furthermore, CMS recognizes that costs for cataract surgery might vary depending on whether surgery was done in an ambulatory surgery center (ASC) or a hospital outpatient department (HOPD), and that costs also can vary depending on whether the cataract surgery is unilateral or bilateral (which it defines as the second surgery being done within 30 days of the first). Consequently, CMS divides episodes of routine cataract surgery into four subgroups and will only compare an episode's costs against the cost of episodes within the same subgroup. The subgroups for routine cataract surgery are unilateral surgery in an ASC; bilateral surgery in an ASC; unilateral surgery in a HOPD; and bilateral surgery in a HOPD.

For the melanoma measure, CMS recognizes two subgroups: head/neck melanoma and trunk/extremity melanoma.

(Note: The 10-episode case minimum requirement applies to the measure as a whole, not to the individual subgroups.)

You score 1-10 points. You can get a score from each of a measure's subgroups, and a weighted average will be used to calculate your measure score. Each subgroup score will be based on how your performance compares with that of other MIPS participants in that subgroup during the current performance year.

Learn more about these measures. Visit the Resource Library at https://qpp.cms.gov to download detailed measure specifications.

You May Get a Cost Improvement Score

Who gets a cost improvement score? The agency won't calculate a cost improvement score for you unless you use the same identifier in 2023 as you did in 2022 (see "Use of TINs and NPIs as Identifiers," page 16).

How CMS calculates your cost improvement score. If you are scored on one or more cost measures in both 2022 and 2023, the number of cost measures with a statistically significant decline in performance is subtracted from the number with a significant improvement. The result is divided by the number of cost measures that were scored for both years. The resulting fraction is multiplied by the "maximum cost improvement score," which is 1%. If, for example, you are scored only on the cataract measure in 2022 and 2023, and there was a significant improvement in 2023, then your cost improvement score would be 1%.

You can't get a negative score. The minimum cost improvement score is 0%.

How CMS Calculates Your Cost Score

This can be described as a three-step process.

1. Your achievement point total is your numerator. For each cost measure you are scored on, you will receive 1 to 10 achievement points based on how your performance compares to the measure's benchmark.

2. The number of points available to you is your denominator. If, for example, you are scored only on the cataract surgery measure, then your denominator would be 10.

3. CMS does the math. After dividing the numerator by the denominator, CMS turns the result into a percentage and adds any cost improvement score (see above). The result is your cost performance category percent score, which contributes up to 30 points to your MIPS final score.

Example. After the performance year is over, CMS determines that a clinician met the case minimum for only the cataract surgery cost measure. Suppose the clinician scores 6.0 achievement points for that measure. Her numerator is 6.0 and, because she was scored on only one cost measure, her denominator is 10. So her cost score is 6.0 ÷ 10 = 0.60, which is reported as a percentage: 60%. (If there was a cost improvement score, it would be added to the 60%.) If cost is weighted at 30% of your MIPS final score (0-100 points), a cost score of 60% would contribute 18 points (60% of 30 points) to that score.

A PERSPECTIVE FROM THE ACADEMY'S D.C. OFFICE

MIPS Value Pathways

Since 2017, there have been two ways to participate in Medicare's Quality Payment Program: 1) via MIPS or 2) as part of an advanced alternative payment model (APM). But in recent years, CMS has made clear that its goal is to sunset "traditional MIPS" and shift clinicians into APMs or into the nascent MIPS value pathways (MVPs). What would that mean for ophthalmologists?

The CMS rationale for MVPs. When CMS initially designed MIPS, it included hundreds of quality measures and more than 90 improvement activities. The goal was to give clinicians flexibility so they could chart their own individualized route through MIPS. During the years that followed, practices have worked hard to master the nuances of MIPS, and the Academy and other professional associations have developed tools and resources to help their members succeed. Despite this, CMS decided that it needed to overhaul the MIPS rules. The agency worried that the plethora of options was overwhelming for practices and made it hard for payers and patients to compare clinicians' performance. This is the agency's rationale for proposing a new framework based around MVPs.

What is an MVP? MVPs each have a specific focus, which is based on a specialty, a medical condition, or a particular population of patients. Each MVP includes a small number of complementary quality measures, improvement activities, and cost measures that are relevant to that focus. MVPs also include a uniform set of promoting interoperability measures and, if feasible, administrative claims-based measures devoted to population health.

From many options to too few. Ophthalmologists currently do not have an MVP developed for them and do not fit into most APMs. They would therefore be left facing penalties if CMS ends traditional MIPS. Unfortunately, CMS has been unclear on how its plans to sunset traditional MIPS would accommodate clinicians who do not have MVPs or APMs available to them.

The current CMS approach overlooks ophthalmology's diverse subspecialties. CMS has been exploring concepts for an ophthalmology MVP. CMS staff have sought collaboration with ophthalmic societies on these concepts and asked for feedback. But when it comes to MVPs, CMS maintains that less is more. This minimalist approach leads to broad, sweeping MVPs that won't be applicable to all the subspecialties within a diverse field such as ophthalmology.

One MVP cannot possibly be applicable to all ophthalmologists. CMS wants to avoid having multiple MVPs per specialty. This is a problem for ophthalmology, which consists of multiple subspecialties with minimal overlap. Many of the quality measures included in a single, sweeping MVP could not be reported by all ophthalmologists and would fail to accurately compare clinicians from different subspecialties. Focusing on procedures or conditions that are relevant to specific subspecialists is the only way to equitably compare clinicians. Additionally, physicians who don't perform cataract surgery or melanoma resection regularly are not eligible for the cost measures that are most relevant to eye care.

For ophthalmology, a move to MVPs imposes burdens with no apparent benefit. Currently, the IRIS Registry provides Academy members with an effective pathway to succeed at MIPS. A shift to an unrefined MVP program would increase provider burden with no demonstrated benefit over traditional MIPS. CMS must clarify the benefit to ophthalmologists and their patients before sunsetting traditional MIPS.

MVPs won't help ophthalmology transition to APMs. In the longer term, CMS may eliminate the MIPS program altogether and encourage—or perhaps mandate—clinicians to participate in APMs. If that's the agency's intention, any overhaul of the MIPS rules should provide clinicians with a bridge to the APM program. But a switch from traditional MIPS to MVPs won't help to prepare clinicians for APMs, as the MVPs don't allow clinicians to become familiar with the requirements of any given APM.

What's next? The Academy continues to press CMS on the importance of building ophthalmology-focused MVPs. CMS launched 12 MVPs this year, but none of them is specific to ophthalmology. Currently, clinicians have the choice of using either traditional MIPS or an MVP, but CMS has noted that it is not feasible to maintain both traditional MIPS and MVP reporting methods indefinitely, due to "the operational burden, complexity, and costs associated with simultaneously maintaining both versions of the program." More will be learned when CMS announces its MIPS proposals for 2024, which will probably be published in July.

Ongoing advocacy. The Academy, along with other societies and coalitions, has continued to raise concerns about MIPS, MVPs, and APMs with CMS. For the latest developments, check your email each Thursday for *Washington Report Express.*

KEEP THIS REFERENCE HANDY

Your Guide to MIPS Acronyms

AAPM	Advanced alternative payment model
ACO	Accountable care organization
ACR measure	All-Cause Readmission measure
API	Application Programming Interface
APM	Alternative payment model
APP	APM performance pathway
ASC	Ambulatory surgical center
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCDS	Common Clinical Data Set[1]
CEHRT	Certified electronic health record technology
CHPL	Certified Health IT Product List
CMS	Centers for Medicare & Medicaid Services
CQM	Clinical quality measure
CTBS	Communications technology–based services
dQM	Digital quality measure
EC	Eligible clinician
eCR	Electronic case reporting
eCQM	Electronic clinical quality measure
EHI	Electronic health information
EHR	Electronic health record
EUC	Extreme and uncontrollable circumstances
FFS	Fee for service
FHIR	Fast Healthcare Interoperability Resources
HARP	HCQIS Access Roles and Profile[2]
HCC	Hierarchical Condition Category
HCQIS	Health Care Quality Information Systems
HHS	Health and Human Services
HIE	Health information exchange
HL7	Health Level Seven International
HPSA	Health professional shortage area
HRSN	Health-related social need
HWR measure	Hospital-Wide Readmission measure
IRIS Registry	Intelligent Research in Sight Registry
MACRA	Medicare Access and CHIP [Children's Health Insurance Program] Reauthorization Bill of 2015
MIPS	Merit-Based Incentive Payment System
MIPS APM	MIPS alternative payment model
MIPS CQM	MIPS clinical quality measure
MIPS EC	MIPS eligible clinician
MVP	MIPS Value Pathway
MSPB measure	Medicare Spending Per Beneficiary measure
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
ONC	Office of the National Coordinator for Health Information Technology
P4P	Pay for performance
PDMP	Prescription Drug Monitoring Program
PECOS	Provider Enrollment, Chain, and Ownership System
PGHD	Patient-generated health data
PHA	Public health agency
PHE	Public Health Emergency
PI	Promoting interoperability
PQRS	Physician Quality Reporting System
PRO	Patient-reported outcome
PROM	Patient-reported outcome measure
QCDR	Qualified Clinical Data Registry
QP	Qualifying APM participant
QPP	Quality Payment Program
RTBT	Real time benefit tool
SAFER Guides	Safety Assurance for EHR Resilience Guides
SDOH	Social driver (or determinant) of health
SOGI	Sexual orientation and gender identity
TIN	Taxpayer Identification Number
TPCC measure	Total Per Capita Cost measure
USCDI	U.S. Core Data for Interoperability[1]

1 The Common Clinical Data Set was used in 2015-edition CEHRT. The U.S. Core Data for Interoperability is used in 2015-edition Cures Update CEHRT.

2 The HARP system involves a CMS secure identity management portal that provides you with a user ID and password for several CMS applications.

Key Dates for Performance Year 2023

2022	Nov. 18	CMS publishes the 2023 MIPS rules in the *Federal Register.*
	Dec. 31	Deadline to form a virtual group for the 2023 performance year.
2023	Jan. 1	Start of 2023 MIPS performance year.
	Spring	CMS starts accepting applications for 1) extreme and uncontrollable circumstances exceptions (see page 17) and 2) hardship exception to PI performance category (see page 48).
	June 15	Deadline to sign agreements for IRIS Registry–EHR integration (if not already integrated).
	June 15	Deadline for IRIS Registry–EHR integrated users to report changes to their practice management system or EHR system, such as an upgrade, a change to their network server, a change to a cloud-based service, or a change to a new system.
	Aug. 1	For new integrated users, or existing users with EHR changes, deadline to complete integration of your EHR system with the IRIS Registry for automated transmission of 2023 quality data.
	August	If reporting MIPS via the IRIS Registry, make sure Academy membership dues are paid so ophthalmologists are in good standing.
	Sept. 1	Deadline to add new clinicians and new locations for practices reporting via IRIS Registry–EHR integration. If notification is not made by this deadline, data for new clinicians or new locations can't be integrated into the dashboard for the 2023 MIPS performance year.
	Oct. 3	Last day to start performance period for PI measures and improvement activities.
	Oct. 31	Deadline for new IRIS Registry users to sign agreements to use the IRIS Registry for manual reporting of improvement activities, PI measures, and quality measures.
	Oct. 31	Last day to request IRIS Registry mapping refinements for selected quality measures.
	Dec. 31	Application deadline for 1) extreme and uncontrollable circumstances exceptions (see page 17) and 2) hardship exception to PI performance category (see page 48).
		End of 2023 MIPS performance year.
2024	Jan. 31	Deadline to submit your 2023 IRIS Registry data release consent form.
		Deadline for IRIS Registry users to enter 2023 quality measure data, attest to PI measures, and attest to improvement activities.
		Last day to submit 2023 MIPS data and attestations to CMS via the IRIS Registry.
	March 31	Last day to submit 2023 MIPS data if reporting directly to the CMS QPP attestation portal.
	Summer/ Fall	CMS will provide you with feedback based on your 2023 performance year data. If you find any scoring errors, you should request a targeted review.
		Targeted review request submission period starts after release of feedback data and ends 60 days later.
	Dec. 1	CMS must notify MIPS participants of their 2025 payment adjustment factor at least 30 days before the 2025 payment year.
2025	Jan. 1	Your Medicare Part B reimbursements will start being adjusted up or down based on your 2023 MIPS performance.
	January	For a limited time, you can check that your 2023 measure data are accurate before CMS posts them at Care Compare. Find out more at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Compare-DAC.

Tip: If you are using the IRIS Registry, check the *2023 IRIS Registry Preparation Kit* for schedules of what needs to be done throughout the year. It describes housekeeping tasks for each quarter, along with tasks that should be done regularly throughout the year. You can download the *2023 IRIS Registry Preparation Kit* at aao.org/iris-registry/user-guide/getting-started or you can buy a print version at the Academy Store.

EYLEA®
(aflibercept) Injection
For Intravitreal Injection

BRIEF SUMMARY—Please see the EYLEA full Prescribing Information available on HCP.EYLEA.US for additional product information.

1 INDICATIONS AND USAGE
EYLEA is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of patients with:

Neovascular (Wet) Age-Related Macular Degeneration (AMD), Macular Edema Following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR).

4 CONTRAINDICATIONS

4.1 Ocular or Periocular Infections
EYLEA is contraindicated in patients with ocular or periocular infections.

4.2 Active Intraocular Inflammation
EYLEA is contraindicated in patients with active intraocular inflammation.

4.3 Hypersensitivity
EYLEA is contraindicated in patients with known hypersensitivity to aflibercept or any of the excipients in EYLEA. Hypersensitivity reactions may manifest as rash, pruritus, urticaria, severe anaphylactic/anaphylactoid reactions, or severe intraocular inflammation.

5 WARNINGS AND PRECAUTIONS

5.1 Endophthalmitis and Retinal Detachments
Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments [*see Adverse Reactions (6.1)*]. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately [*see Patient Counseling Information (17)*].

5.2 Increase in Intraocular Pressure
Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA [*see Adverse Reactions (6.1)*]. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with vascular endothelial growth factor (VEGF) inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.

5.3 Thromboembolic Events
There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

6 ADVERSE REACTIONS
The following potentially serious adverse reactions are described elsewhere in the labeling:
- Hypersensitivity [*see Contraindications (4.3)*]
- Endophthalmitis and retinal detachments [*see Warnings and Precautions (5.1)*]
- Increase in intraocular pressure [*see Warnings and Precautions (5.2)*]
- Thromboembolic events [*see Warnings and Precautions (5.3)*]

6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in other clinical trials of the same or another drug and may not reflect the rates observed in practice.
A total of 2980 patients treated with EYLEA constituted the safety population in eight phase 3 studies. Among those, 2379 patients were treated with the recommended dose of 2 mg. Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment. The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.

Neovascular (Wet) Age-Related Macular Degeneration (AMD). The data described below reflect exposure to EYLEA in 1824 patients with wet AMD, including 1223 patients treated with the 2-mg dose, in 2 double-masked, controlled clinical studies (VIEW1 and VIEW2) for 24 months (with active control in year 1).
Safety data observed in the EYLEA group in a 52-week, double-masked, Phase 2 study were consistent with these results.

Table 1: Most Common Adverse Reactions (≥1%) in Wet AMD Studies

	Baseline to Week 52		Baseline to Week 96	
Adverse Reactions	**EYLEA (N=1824)**	**Active Control (ranibizumab) (N=595)**	**EYLEA (N=1824)**	**Control (ranibizumab) (N=595)**
Conjunctival hemorrhage	25%	28%	27%	30%
Eye pain	9%	9%	10%	10%
Cataract	7%	7%	13%	10%
Vitreous detachment	6%	6%	8%	8%
Vitreous floaters	6%	7%	8%	10%
Intraocular pressure increased	5%	7%	7%	11%
Ocular hyperemia	4%	8%	5%	10%
Corneal epithelium defect	4%	5%	5%	6%
Detachment of the retinal pigment epithelium	3%	3%	5%	5%
Injection site pain	3%	3%	3%	4%
Foreign body sensation in eyes	3%	4%	4%	4%
Lacrimation increased	3%	1%	4%	2%
Vision blurred	2%	2%	4%	3%
Intraocular inflammation	2%	3%	3%	4%
Retinal pigment epithelium tear	2%	1%	2%	2%
Injection site hemorrhage	1%	2%	2%	2%
Eyelid edema	1%	2%	2%	3%
Corneal edema	1%	1%	1%	1%
Retinal detachment	<1%	<1%	1%	1%

Less common serious adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal tear, and endophthalmitis.

Macular Edema Following Retinal Vein Occlusion (RVO). The data described below reflect 6 months exposure to EYLEA with a monthly 2 mg dose in 218 patients following central retinal vein occlusion (CRVO) in 2 clinical studies (COPERNICUS and GALILEO) and 91 patients following branch retinal vein occlusion (BRVO) in one clinical study (VIBRANT).

Table 2: Most Common Adverse Reactions (≥1%) in RVO Studies

	CRVO		BRVO	
Adverse Reactions	**EYLEA (N=218)**	**Control (N=142)**	**EYLEA (N=91)**	**Control (N=92)**
Eye pain	13%	5%	4%	5%
Conjunctival hemorrhage	12%	11%	20%	4%
Intraocular pressure increased	8%	6%	2%	0%
Corneal epithelium defect	5%	4%	2%	0%
Vitreous floaters	5%	1%	1%	0%
Ocular hyperemia	5%	3%	2%	2%
Foreign body sensation in eyes	3%	5%	3%	0%
Vitreous detachment	3%	4%	2%	0%
Lacrimation increased	3%	4%	3%	0%
Injection site pain	3%	1%	1%	0%
Vision blurred	1%	<1%	1%	1%
Intraocular inflammation	1%	1%	0%	0%
Cataract	<1%	1%	5%	0%
Eyelid edema	<1%	1%	1%	0%

Less common adverse reactions reported in <1% of the patients treated with EYLEA in the CRVO studies were corneal edema, retinal tear, hypersensitivity, and endophthalmitis.

Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR). The data described below reflect exposure to EYLEA in 578 patients with DME treated with the 2-mg dose in 2 double-masked, controlled clinical studies (VIVID and VISTA) from baseline to week 52 and from baseline to week 100.

Table 3: Most Common Adverse Reactions (≥1%) in DME Studies

	Baseline to Week 52		Baseline to Week 100	
Adverse Reactions	**EYLEA (N=578)**	**Control (N=287)**	**EYLEA (N=578)**	**Control (N=287)**
Conjunctival hemorrhage	28%	17%	31%	21%
Eye pain	9%	6%	11%	9%
Cataract	8%	9%	19%	17%
Vitreous floaters	6%	3%	8%	6%
Corneal epithelium defect	5%	3%	7%	5%
Intraocular pressure increased	5%	3%	9%	5%
Ocular hyperemia	5%	6%	5%	6%
Vitreous detachment	3%	3%	8%	6%
Foreign body sensation in eyes	3%	3%	3%	3%
Lacrimation increased	3%	2%	4%	2%
Vision blurred	2%	2%	3%	4%
Intraocular inflammation	2%	<1%	3%	1%
Injection site pain	2%	<1%	2%	<1%
Eyelid edema	<1%	1%	2%	1%

Less common adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal detachment, retinal tear, corneal edema, and injection site hemorrhage.
Safety data observed in 269 patients with nonproliferative diabetic retinopathy (NPDR) through week 52 in the PANORAMA trial were consistent with those seen in the phase 3 VIVID and VISTA trials (see Table 3 above).

6.2 Immunogenicity
As with all therapeutic proteins, there is a potential for an immune response in patients treated with EYLEA. The immunogenicity of EYLEA was evaluated in serum samples. The immunogenicity data reflect the percentage of patients whose test results were considered positive for antibodies to EYLEA in immunoassays. The detection of an immune response is highly dependent on the sensitivity and specificity of the assays used, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to EYLEA with the incidence of antibodies to other products may be misleading.
In the wet AMD, RVO, and DME studies, the pre-treatment incidence of immunoreactivity to EYLEA was approximately 1% to 3% across treatment groups. After dosing with EYLEA for 24-100 weeks, antibodies to EYLEA were detected in a similar percentage range of patients. There were no differences in efficacy or safety between patients with or without immunoreactivity.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy
Risk Summary
Adequate and well-controlled studies with EYLEA have not been conducted in pregnant women. Aflibercept produced adverse embryofetal effects in rabbits, including external, visceral, and skeletal malformations. A fetal No Observed Adverse Effect Level (NOAEL) was not identified. At the lowest dose shown to produce adverse embryofetal effects, systemic exposures (based on AUC for free aflibercept) were approximately 6 times higher than AUC values observed in humans after a single intravitreal treatment at the recommended clinical dose [*see Animal Data*].
Animal reproduction studies are not always predictive of human response, and it is not known whether EYLEA can cause fetal harm when administered to a pregnant woman. Based on the anti-VEGF mechanism of action for aflibercept, treatment with EYLEA may pose a risk to human embryofetal development. EYLEA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Data
Animal Data
In two embryofetal development studies, aflibercept produced adverse embryofetal effects when administered every three days during organogenesis to pregnant rabbits at intravenous doses ≥3 mg per kg, or every six days during organogenesis at subcutaneous doses ≥0.1 mg per kg.
Adverse embryofetal effects included increased incidences of postimplantation loss and fetal malformations, including anasarca, umbilical hernia, diaphragmatic hernia, gastroschisis, cleft palate, ectrodactyly, intestinal atresia, spina bifida, encephalomeningocele, heart and major vessel defects, and skeletal malformations (fused vertebrae, sternebrae, and ribs; supernumerary vertebral arches and ribs; and incomplete ossification). The maternal No Observed Adverse Effect Level (NOAEL) in these studies was 3 mg per kg. Aflibercept produced fetal malformations at all doses assessed in rabbits and the fetal NOAEL was not identified. At the lowest dose shown to produce adverse embryofetal effects in rabbits (0.1 mg per kg), systemic exposure (AUC) of free aflibercept was approximately 6 times higher than systemic exposure (AUC) observed in humans after a single intravitreal dose of 2 mg.

8.2 Lactation
Risk Summary
There is no information regarding the presence of aflibercept in human milk, the effects of the drug on the breastfed infant, or the effects of the drug on milk production/excretion. Because many drugs are excreted in human milk, and because the potential for absorption and harm to infant growth and development exists, EYLEA is not recommended during breastfeeding.
The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for EYLEA and any potential adverse effects on the breastfed child from EYLEA.

8.3 Females and Males of Reproductive Potential
Contraception
Females of reproductive potential are advised to use effective contraception prior to the initial dose, during treatment, and for at least 3 months after the last intravitreal injection of EYLEA.

Infertility
There are no data regarding the effects of EYLEA on human fertility. Aflibercept adversely affected female and male reproductive systems in cynomolgus monkeys when administered by intravenous injection at a dose approximately 1500 times higher than the systemic level observed humans with an intravitreal dose of 2 mg. A No Observed Adverse Effect Level (NOAEL) was not identified. These findings were reversible within 20 weeks after cessation of treatment.

8.4 Pediatric Use
The safety and effectiveness of EYLEA in pediatric patients have not been established.

8.5 Geriatric Use
In the clinical studies, approximately 76% (2049/2701) of patients randomized to treatment with EYLEA were ≥65 years of age and approximately 46% (1250/2701) were ≥75 years of age. No significant differences in efficacy or safety were seen with increasing age in these studies.

17 PATIENT COUNSELING INFORMATION
In the days following EYLEA administration, patients are at risk of developing endophthalmitis or retinal detachment. If the eye becomes red, sensitive to light, painful, or develops a change in vision, advise patients to seek immediate care from an ophthalmologist [*see Warnings and Precautions (5.1)*].
Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations [*see Adverse Reactions (6)*]. Advise patients not to drive or use machinery until visual function has recovered sufficiently.

REGENERON

Manufactured by:
Regeneron Pharmaceuticals, Inc.
777 Old Saw Mill River Road
Tarrytown, NY 10591

Issue Date: 08/2019
Initial U.S. Approval: 2011

Based on the August 2019
EYLEA® (aflibercept) Injection full
Prescribing Information.

EYL.20.09.0052

Start With EYLEA From the First Injection in Wet AMD

EYLEA® (aflibercept) Injection For Intravitreal Injection

Demonstrated maintenance of vision

- **≈95% of patients maintained their vision** (<15 ETDRS letters lost) with EYLEA at Year 1 (primary endpoint)[1]
  – VIEW 1 (n=605); VIEW 2 (n=615)[1,*]

Effective regardless of fluid status

- Vision outcomes in patients **with and without early persistent fluid** (*post hoc* subgroup analysis)[3,†]

Long-term vision outcomes

- EYLEA maintained **+7.1 letters of BCVA gain at Year 4** in the VIEW 1 extension study (n=323)[2]

Broad national coverage

- 77% of lives have access to EYLEA first line, covering **236 million lives nationwide**[4,‡]

When You See Wet AMD, Consider EYLEA First Line

LEARN MORE at hcp.eylea.us

VIEW 1 and VIEW 2 Clinical Trial Designs: Two multicenter, double-masked clinical studies in which patients with Wet AMD (N=2412; age range: 49-99 years, with a mean of 76 years) were randomized to receive: 1) EYLEA 2 mg Q8W following 3 initial monthly doses; 2) EYLEA 2 mg Q4W; 3) EYLEA 0.5 mg Q4W [not an approved dose]; or 4) ranibizumab 0.5 mg Q4W. Protocol-specified visits occurred every 28 (±3) days. In both studies, the primary efficacy endpoint was the proportion of patients with Wet AMD who maintained vision, defined as losing <15 letters of visual acuity at Week 52, compared with baseline.[1]

VIEW 1 Extension Clinical Trial Design: Prospective, open-label, single-arm, multicenter, long-term safety and tolerability study of patients who completed VIEW 1 through Week 96 (n=323; mean age: 79 years). All patients received EYLEA 2 mg on a modified quarterly dosing schedule (maximum treatment interval: Q12W) that was later amended to dosing at least Q8W through Week 212. The primary endpoint was the safety and tolerability of EYLEA.[3]

*Includes patients from both EYLEA Q4W and Q8W treatment arms. EYLEA was clinically equivalent to ranibizumab.
†Early persistent fluid (intraretinal [cystic] or subretinal) was defined as presence of fluid at the first 4 visits (baseline, Week 4, Week 8, and Week 12) after having received 3 initial monthly injections (baseline, Week 4, and Week 8) as seen on TD-OCT.
‡Data represent payers across the following channels as of November 2022: Medicare Part B, Commercial, Medicare Advantage, and VA. Individual patient coverage is subject to patient's specific plan.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

- EYLEA is contraindicated in patients with ocular or periocular infections, active intraocular inflammation, or known hypersensitivity to aflibercept or to any of the excipients in EYLEA.

WARNINGS AND PRECAUTIONS

- Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately. Intraocular inflammation has been reported with the use of EYLEA.
- Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with VEGF inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.
- There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

ADVERSE REACTIONS

- Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment.
- The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.
- Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations. Advise patients not to drive or use machinery until visual function has recovered sufficiently.

INDICATIONS

EYLEA® (aflibercept) Injection 2 mg (0.05 mL) is indicated for the treatment of patients with Neovascular (Wet) Age-related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), and Diabetic Retinopathy (DR).

Please see Brief Summary of full Prescribing Information on the following page.

References: 1. EYLEA® (aflibercept) Injection full U.S. Prescribing Information. Regeneron Pharmaceuticals, Inc. August 2022. **2.** Kaiser PK, Singer M, Tolentino M, et al. Long-term safety and visual outcome of intravitreal aflibercept in neovascular age-related macular degeneration: VIEW 1 extension study. *Ophthalmol Retina*. 2017;1(4):304-313. doi:10.1016/j.oret.2017.01.004 **3.** Jaffe GJ, Kaiser PK, Thompson D, et al. Differential response to anti-VEGF regimens in age-related macular degeneration patients with early persistent retinal fluid. *Ophthalmology*. 2016;123(9):1856-1864. doi:10.1016/j.ophtha.2016.05.016 **4.** Data on file. Regeneron Pharmaceuticals, Inc.

BCVA, best-corrected visual acuity; ETDRS, Early Treatment Diabetic Retinopathy Study; Q4W, every 4 weeks; Q8W, every 8 weeks; Q12W, every 12 weeks; TD-OCT, time domain–optical coherence tomography.

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777 Old Saw Mill River Road, Tarrytown, NY 10591 12/2022 EYL.22.12.0032