







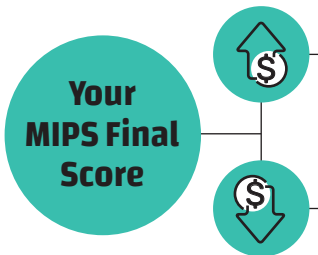
2024 MIPS Guidebook

A Road Map to Success for Doctors of Optometry

In 2007, the Centers for Medicare & Medicaid Services (CMS) implemented a new way to pay doctors. This system is called the Merit-Based Incentive Payment System (MIPS), which requires doctors to more robustly report their quality, electronic health record (EHR) use, and practice improvement activities to get paid at the most adequate levels. This AOA guide assists Doctors of Optometry in learning how to become a successful MIPS participant. In addition, now available on EyeLearn is a webinar by the AOA's Coding and Reimbursement Committee that explains the changes to MIPS for 2024 and how they will impact doctors of optometry.

MIPS Made Easy!

A single MIPS **Final Score** will factor in performance in **4 Weighted Performance Categories**:

 1 Quality (large practices 55%, small practices 50%) Think PQRS! Reporting "quality" is paramount.	 2 Cost (0%) Doctors of optometry are exempt from submitting Cost measures.	 3 Improvement Activities (large practices 15%, small practices 50%) How are you improving overall public health?	 4 Promoting Interoperability (large practices 30%, small practices 0%) Think Meaningful Use!	 <p>A MIPS Composite Score above the CMS threshold will get you a bonus (pay increase)</p> <p>A MIPS Composite Score below the CMS threshold will get you a penalty (pay reduction)</p>
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NOTE: Only 3 of the 4 categories count for optometry since cost will be valued at zero.

The AOA thanks the Quality Improvement and Data Committee and the Coding and Reimbursement Committee for their guidance and input in developing this resource.

MIPS Made Easy. Follow these 3 steps.

1. Review program requirements. Know the exclusions!
2. Follow the recommendations in the check list.
3. Know the minimum requirements for protecting your income and avoiding penalties. The performance threshold TO AVOID PENALTIES is set at 75 points.
4. Know the payment adjustment range for 2026 (based on PY 2024): -9 percent to +9 percent, plus any scaling to achieve budget neutrality.

Reporting Requirements

1 Quality

For Traditional Medicare and Railroad Medicare, in PY 2024 physicians must correctly report at least 75% of eligible encounters for the quality measures they report for the full 12 month period. For EHR reporting, this applies to all insurance types and patients.

2 Cost

Nothing for you to report. Cost is not calculated for optometrists, but will be calculated by CMS.

3 Improvement Activities (IA)

You must report for 90+ continuous days.

4 Promoting Interoperability (PI)

(*NEW*) You must report for 180+ continuous days.

- The payment adjustment for 2026 (based on 2024 performance) will range from -9 percent to +9 percent, plus any scaling to achieve budget neutrality.
- A “yes” response is required to fulfill the SAFER Guide measure beginning with the 2024 performance period.

MIPS Value Pathways (MVPs)

- None of the 16 MVPs for PY 2024 are appropriate for optometry but this could change in future years.
- They are intended to align and connect measures and activities across all of the MIPS performance categories for different specialties or conditions.
- They will be voluntary through PY 2027. CMS will sunset traditional reporting sometime after CY 2026.

Individual v. Group Reporting

- Doctors in group practices can choose to participate in MIPS as a group. Doctors in small practices (≤ 15 providers) can opt to report as individuals, a group, or both. CMS will use the best score for their calculations.
- A “group” is defined as 2 or more Medicare providers in the same tax ID number.
- CMS will accept opt-in group reporting and determine if your practice will receive a BONUS, PENALTY or NEUTRAL adjustment in your overall CMS payables for 2025.

Know the Exclusions!

(See MIPS Opt-in section below) These exclusions can apply to a group or an individual. Doctors who qualify for an exclusion from MIPS, will not be required to meet program criteria if they meet any of the following Low Volume Threshold criteria:

Exclusion 1: New Medicare-enrolled physicians

If 2024 is your first year submitting claims to Medicare.

Exclusion 2: Low-Volume Threshold

If you have Medicare allowable charges less than or equal to \$90,000 and/or if you provide care for 200 and fewer Part B-enrolled Medicare beneficiaries and/or you provide less than or equal to 200 covered professional services. If a practice chooses to participate as a group, the low-volume exclusion will be assessed at the group level.

Exclusion 3: Qualifying APM Participants (QP) and Partial Qualifying APM Participant (Partial QP)

If you participate in a qualifying advanced alternative payment model (Think ACO). However, most Doctors of Optometry don't participate in APMs.

Considerations for Small Practices!

Small practices (15 or fewer clinicians) are eligible for certain program flexibilities. You can qualify for these flexibilities if you are a clinician in a small practice:

- If you are identified as a small practice, you'll earn 2x the points for each Improvement Activity (you can earn up to 40 points). This is also true for practices in Health Professional Shortage Areas or rural zip codes.
- If you submit at least one quality measure during PY 2024, you will receive 6 bonus points in the quality performance category to be applied in the 2026 payment year.
- For small practices (15 or fewer clinicians), measures will be scored on a 3-10 point scale.
- For large practices (16 or more clinicians), measures will be scored on a 1-10 point scale.
- Because optometrists are exempt from submitting data for the Cost category and small practices are exempt from submitting data for the Promoting Interoperability category, the weights for Cost (30%) and Promoting Interoperability (25%) will be given to other categories. Therefore, a small practice's performance will be based 50% on Quality and 50% on Improvement Activities.
- Earn 3 points (not 0 points) for Quality Measures: 1) Not Meeting Data Completeness; 2) Not Meeting Case Minimum Requirements; 3) Not reliably scored against a benchmark.

MIPS Opt-In

If you are an individual or a group and you meet one or two of the three Low Volume Threshold criteria, you can opt-in to the MIPS program and be eligible for an incentive, or at risk for a penalty. You must complete the CMS process for indicating you would like to opt-in to the program. This process will be completed during attestation in 2024.

MIPS Performance Year

- The MIPS performance year begins on January 1 and ends on December 31 each year.
- If you are MIPS eligible, all data you collect from January 1, 2024 through December 31, 2024 must be reported by March 31, 2025. You will receive your payment adjustment between January 1, 2026 and December 31, 2026.
- The last day to begin a 90+ day reporting period is Oct 3, 2024.

Quality in 2024: % of your 0-100 MIPS Score (large practices = 55%; small practices = 50%)

- Doctors of Optometry must report at least 6 QUALITY measures.
- You must include one “Outcomes” measure; however, if you are unable to report an outcomes measure, then one “High Priority” measure must be selected as one of your 6 Quality measures.
- If you are reporting through your EHR, you must report on 75% of your patients across all payers.
- EHR must be certified to the 2015 Edition Cures Update by the last day of the performance period.
- For large practices (16 or more clinicians) measures are scored on a 1-10 point scale.
- EHR reporting is for all patients; However, if you are engaging only in claims-based reporting, only Traditional Medicare and Railroad Medicare Part B claims will count toward MIPS (excludes Medicare Advantage and private insurance patients, unless these plans have a quality program of their own).

Recommended Quality Measures

- Below is a summary of recommended quality measures for reporting.
- Some measures are only available for reporting for certain reporting methods (claims, CQM or eCQM).
- Below the summary of recommended quality measures is a chart detailing how topped out measures are scored.
- Providers must read each measure they choose to ensure they understand the new guidance.
- Measures 141 and 226 have changed significantly from last year’s guidance.

Claims Measures

The following are measures available for claims reporting that are most pertinent to Doctors of Optometry.

Measure	Description	CMS eCQM ID	Measure Type	High Priority	Medicare Part B Claims	EHR
001	Ha1C	CMS122v12	Intermediate Outcome	Yes	Yes	Yes
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure by 20% OR Documentation of a Plan of Care	N/A	Outcome	Yes	Yes	No
155	Falls: Plan of Care	N/A	Process	Yes	Yes	Yes
181	Elder Maltreatment Screen and Follow-Up Plan	N/A	Process	Yes	Yes	No
226	Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v12	Process	No	Yes	Yes
236	Controlling High Blood Pressure	CMS165v12	Intermediate Outcome	Yes	Yes	Yes
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS22v12	Process	No	Yes	Yes

Note: Measure 128 (Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan) is not available for Claims reporting. It is only available for MVP reporting.

eCQM Measures

The following are eCQM measures that are most pertinent to Doctors of Optometry. Because these measures are reported via EHR, Doctors of Optometry must verify with their vendors which measures they have chosen to report and how to report them.

Measure	Description	CMS eCQM ID	Measure Type	High Priority	Medicare Part B Claims	EHR
001	Ha1C	CMS122v12	Intermediate Outcome	Yes	Yes	Yes
12	POAG: Optic Nerve Evaluation	CMS143v12	Process	No	No	Yes
19	Diabetic Retinopathy: Communication with Physician	CMS142v12	Process	Yes	No	Yes
117	Diabetes Eye Exam	CMS131v12	Process	No	No	Yes
130	Documentation of Current Medications	CMS68v13	Process	Yes	No	No
191*	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	CMS133v12	Outcome	Yes	No	Yes
226	Tobacco Use: Screening and Cessation Intervention	CMS138v12	Process	No	Yes	Yes
236	Controlling HBP	CMS165v12	Intermediate Outcome	Yes	Yes	Yes
238	High risk medication Older Patient	CMS156v12	Process	Yes	No	Yes
281	Dementia Cognition Assessment	CMS149v12	Process	No	No	Yes
317	Screening for HBP and Follow-up Documented	CMS22v11	Process	No	Yes	Yes
318	Falls: Screening for Future Risk	CMS139v12	Process	Yes	No	Yes
374	Closing the Referral Loop	CMS50v12	Process	Yes	Yes	Yes

*Can't be used with -55 modifier, therefore can't be used for post-op care.

CQM Measures

The following are CQM measures that are most pertinent to Doctors of Optometry. These measures are reported via clinical registries. Currently, no clinical registry exists that is specific to optometry.

Measure Tile	Description	CMS eCQM ID	Measure Type	High Priority	Medicare Part B Claims	EHR
001	Ha1C	CMS122v12	Intermediate Outcome	Yes	Yes	Yes
19	Diabetic Retinopathy: Communication with Physician Managing Ongoing Diabetes Care	CMS142v12	Process	Yes	No	Yes
117	Diabetes Eye Exam	CMS131v12	Process	No	No	Yes
130	Documentation of Current Medications	CMS68v13	Process	Yes	No	No
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure by 20% OR Documentation of a Plan of Care	N/A	Outcome	Yes	Yes	No
155	Falls: Plan of Care	N/A	Process	Yes	Yes	Yes
191	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	CMS133v12	Outcome	Yes	No	Yes
226	Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v12	Process	No	Yes	Yes
236	Controlling High Blood Pressure	CMS165v12	Intermediate Outcome	Yes	Yes	Yes
238	Use of High Risk Medications in Older Adults	CMS138v12	Outcome	Yes	No	Yes
282	Dementia: Functional Status Assessment	N/A	Process	No	No	No

(CQM Measures continued on next page)

CQM Measures

The following are CQM measures that are most pertinent to Doctors of Optometry.

Measure Tile	Description	CMS eCQM ID	Measure Type	High Priority	Medicare Part B Claims	EHR
286	Dementia: Safety Concern Screening and Follow-Up for Patients with Dementia	N/A	Process	Yes	No	No
288	Dementia Caregiver Education Support	N/A	Process	Yes	No	No
303	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	N/A	Outcome	Yes	No	No
304	Cataracts: Patient Satisfaction within 90 Days of Cataract Surgery	N/A	Patient Engagement	Yes	No	No
317	Screening for HBP and Follow-up Documented	CMS22v12	Process	No	Yes	Yes
374	Closing the Referral Loop	CMS50v12	Process	Yes	Yes	Yes
384	Adult Primary Rhegmatogenous RD Surgery: No Return in 90 Days	N/A	Outcome	Yes	No	No
385	Adult Primary Rhegmatogenous RD Surgery: VA Improvement -90 Days	N/A	Outcome	Yes	No	No
389	Cataract Surgery: Difference Between	N/A	Outcome	Yes	No	No
431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	N/A	Process	No	No	No
487	Screening for SDOH	N/A	Process	Yes	No	No

NOTE: Optometry cannot report measures 191, 303, 304, 384, 385, 389

(CQM Measures continued on next page)

CQM Measures

The following are CQM measures that are most pertinent to Doctors of Optometry.

Measure Tile	Description	CMS eCQM ID	Measure Type	High Priority	Medicare Part B Claims	EHR
493	Adult Immunization Status	N/A	Process	No	No	No
498	Connection to Community Service Provider	N/A	Process	Yes	Yes	No
499	Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy		Process	No	No	No
500	Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up	N/A	Process	No	No	No
501	Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	N/A	Process	No	No	No

NOTE: Optometry cannot report measures 191, 303, 304, 384, 385, 389

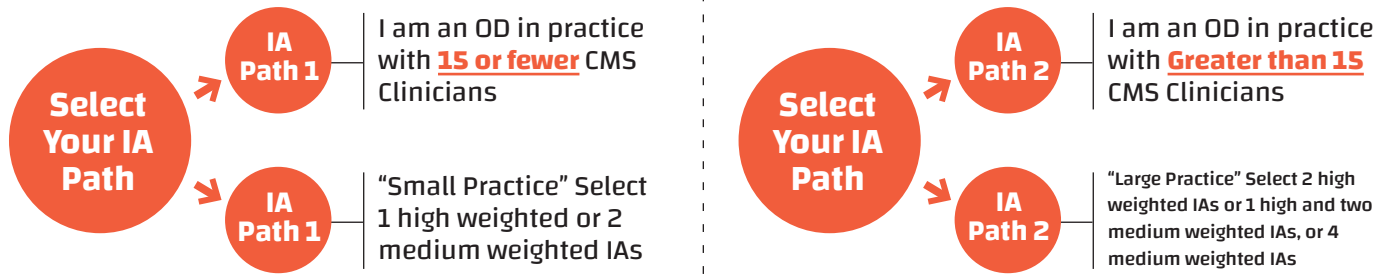
Scoring of Topped Out Measures

Measure	7 Points	10 Points
19 MIPS CQM	X	
117 MIPS CQM	X	
128 MIPS CQM		X
130 MIPS CQM, eCQM	X	
155 MIPS CQM, Claims	X	
226 Claims		X
238 MIPS CQM, eCQM		X
317 Claims	X	
374 MIPS CQM	X	
384 MIPS CQM	X	

COST IN 2024: 0% of your 0-100 MIPS score

- Cost is not calculated for optometrists. However, this could change in the future.
- The Cost category is an attempt to measure how much you cost CMS to provide care to patients.
- There is nothing for doctors of optometry to submit when the Cost score is analyzed.
- This score is derived from calculations based on claims data.
- Certain conditions, i.e., diabetes, are emphasized when calculating Cost, or Resource Use, scores.
- If your Cost score is zero, CMS may reapply these cost score points to other categories (Quality & Promoting Interoperability).

Improvement Activities in 2024: % of your 0-100 MIPS Score (large practices = 15%; small practices = 15%)



Your **IA** requirements depend on how large your practice is (by Tax ID#). IA's must be completed for a period of 90+ days. The below chart lists only the most relevant improvement activities for optometrists. It is NOT an exhaustive list.

Activity	CMS Reference Number	Weight	Additional Guidance For Meeting IA Reporting Requirements
Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record	IA_EPA_1	High	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.
Comprehensive Eye Exams	IA_AHE_7	Medium	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 AOA's VISION USA, or; promoting access to vision rehabilitation services as appropriate for individuals with chronic vision impairment.
Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop	IA_CC_1	Medium	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.

For a more exhaustive list of IA measures, please see slides 60-74 of Dr. Wartman's presentation on MIPS 2024 (found at AOA EyeLearn).

(Improvement Activities in 2024 continued on next page)

Your **IA** requirements depend on how large your practice is (by Tax ID#). IA's must be completed for a period of 90+ days. The below chart lists only the most relevant improvement activities for optometrists. It is NOT an exhaustive list.

Engagement of patients through implementation of improvements in patient portal.	IA_BE_4	Medium	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.
Enhance Engagement of Medicaid and Other Underserved Populations	IA_AHE_1	High	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).
Regularly Assess Patient Experience of Care and Follow Up on Findings	IA_BE_6	High	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.
Care coordination agreements that promote improvements in patient tracking across settings	IA_CC_12	Medium	Establish effective care coordination and active referral management that could include one or more of the following: <ul style="list-style-type: none"> • 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.

For a more exhaustive list of IA measures, please see slides 60-74 of Dr. Wartman's presentation on MIPS 2024 (found at AOA EyeLearn).

Promoting Interoperability: % of your 0-100 MIPS Score (large practices = 30%; small practices = 0%)

You must be using an EHR with Cures Update functionality by the first day of your 90-day performance period in 2024, and it must be certified to the ONC health IT certification criteria by the last day of the performance period.

2024 Scoring Methodology: Four Objectives

- e-Prescribing
- Health Information Exchange
- Provider to Patient Exchange (portal access)
- Public Health and Clinical Data Exchange (registry)

You will be required to report certain measures from each objective, with performance-based scoring at the individual measure-level. Each measure will be scored based on the performance for that measure, which is based on the submission of a numerator and denominator, except for the measures associated with the Public Health and Clinical Data Exchange (registry) objective, which requires “yes or no” submissions. The score for each individual measure will be added together to calculate the PI performance score of up to 100 possible points for each MIPS eligible clinician.

IMPORTANT!

You must complete the activities required by the HIPAA Security Risk Assessment AND the SAFER Guide, submit their complete numerator and denominator or Yes/No data for all required measures, and attest to the actions to limit or restrict compatibility or interoperability of CEHRT statement. The SAFER Guide assessment must be completed annually, and a “yes” response is required to fulfill the measure beginning with the 2024 performance period. Failure to report at least a “1” in all required measures with a numerator or reporting a “No” for a Yes/No response measure will result in a total score of 0 points for the Promoting Interoperability performance category.

(Promoting Interoperability continued on next page)

Promoting Interoperability

Objective	Measure	Maximum Points	Exclusions
Electronic Prescribing	e-Prescribing	10 Points	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the
	Query of PDMP*	10 Points*	1) Any MIPS eligible clinician who is unable to electronically prescribe schedule II, III, or IV drugs in accordance with applicable law during the performance period; 2) Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during reporting period; or 3) Any MIPS eligible clinician who has excessive workflow or cost burden.
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 Points*	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	15 Points*	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 fewer than 100 times during the performance period.
	- OR -		
	Health Information Exchange Bi-Directional Exchange	30 Points*	N/A
	- OR -		
	Enabling Exchange under TEFCA*	30 Points*	N/A
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 Points*	N/A
Public Health and Clinical Data Exchange (Optional)	Report the following two measures*: • Immunization Registry Reporting • Electronic Case Responding	25 Points*	For these measures you may claim an exclusion if you don't administer vaccinations; or if there is no registry available to accept data at start of the reporting period, OR if there is no registry that has declared readiness to accept data six months prior to the reporting period.
	Report one of the following two measures*: • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	5 Points (bonus)*	