AMERICAN ACADEMY OF OPHTHALMOLOGY®

Roadmaps

The Academy releases Small and Large Practice Roadmaps each year to help guide you through the decision-making for successful MIPS reporting. Small practices have some scoring advantages over their large practice counterparts, thus the reason for separate roadmaps.

For the 2026 Performance Year, the threshold to avoid a penalty on 2028 reimbursements from Medicare Fee-For-Service is a MIPS final score of 75 points.

How you earn those points depends upon which performance categories make up your MIPS score. The decisions you face depend upon how high you can score in the quality performance category and whether you qualify for the cost and promoting interoperability (PI) categories. For example, an ophthalmology practice that does not perform cataract surgery or melanoma resections is unlikely to be subject to the cost performance category. Additionally, small practices (15 or fewer eligible clinicians) are automatically exempt from reporting in the PI category.

Reweighting Scenario	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 promoting interoperability (PI)	Small	40%	0%	30%	30%
	Large	55%	0%	15%	30%
No quality	Small or large	0%	55%	15%	30%
No improvement activities	Small or large	45%	25%	0%	30%
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 only score you on one performance category, you would be assigned a MIPS final score of 75 points, which is enough to avoid the payment penalty.					

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

Your MIPS final score (0-100 points) is based on up to four performance category scores, which are weighted as shown in the table above (e.g., if quality is weighted at 30%, it contributes up to 30 points to your MIPS final score).

CMS may reweight how performance categories contribute to your MIPS final score if it determines that you shouldn't be scored on one or more categories (e.g., if extreme and uncontrollable circumstances apply, if a promoting interoperability exception applies, or if you don't meet the case minimum for any cost measures).

AMERICAN ACADEMY OF OPHTHALMOLOGY®

2026 Solo and Small-Practice Roadmap for MIPS

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

Verify your status by using the QPP Participation Status Tool (https://qpp.cms.gov/participation-lookup).

- CMS released the initial eligibility status December 2025 and will release the final eligibility status December 2026.

Clinicians qualify for an automatic exemption from MIPS if they meet one or more of the following criteria:

- New to Medicare for 2026 and hasn't previously submitted claims under Medicare
- Less than or equal to $90,000 in Medicare Part B service allowed charges
- Provides covered professional services to 200 or fewer Medicare Part B patients
- Provides 200 or fewer covered professional services to Part B patients. When you treat more than 200 patients you are, by definition, performing at least 200 services
- Clinician is a qualifying participant in an Advanced Alternative Payment Model.

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

- October 1, 2024 – September 30, 2025, and/or
- October 1, 2025 - September 30, 2026

Please note that if the clinician is reporting as a part of a group, the low-volume threshold is evaluated at the group level.

Step 2. Are You in a Small Practice?

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

- If you are a large practice, please refer to the Large Practice Roadmap on page 22.

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

Goal	Effect on Reimbursement	MIPS Final Score Required
Avoid the maximum 9% Penalty	Avoids the full 9% penalty on your 2028 Medicare Part B services reimbursements. (Between 18.76 and 74.99 points, the penalty is on a sliding scale, ranging from approximately 6.75% - 0.01%)	18.76 points
Avoids a penalty	Avoids a penalty on your 2028 Medicare Part B services reimbursements	75 points
Small bonus	Qualifies you for a small bonus on your 2028 Medicare Part B services reimbursements	Above 75 points

Step 4. How to Achieve Your Goal for the 2026 Performance Year

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

MIPS Performance Category	2026 Score Default Weight
Quality	30%
Promoting interoperability	25%
Improvement activities	15%
Cost	30%

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

For those eligible for the cost performance category, do all the following to avoid a penalty (requires a MIPS final score of 75 points).

Quality performance category:

- IRIS Registry participants can choose to report via traditional MIPS, the Complete Ophthalmologic Care MIPS Value Pathway (MVP), or both. If submitting through both, CMS will apply the higher scoring submission.

- If you are reporting via traditional MIPS, you are required to report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.

- For practices reporting through the Complete Ophthalmologic Care MVP, you are required to report on 4 quality measures. However, you must select your quality measures from a more limited subset of measures. The subset of measures can be found on the Complete Ophthalmologic Care MVP webpage.

- This category must be performed for the full calendar year on at least 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).

- CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.

- Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

- All small practices that report on at least one quality measure will receive 6 bonus points for the quality category.

- For small practices *without* EHR:

    - Fully report on at least 75% of denominator-eligible patients to meet the data completeness threshold and provide the total eligible patient populations for the reporting period AND with at least 20 patients in the denominator for all quality measures.

  - You must achieve a quality category score of at least 88 out of 100 (with the automatic PI hardship for small practices assuming the cost category contributes 10 points out of 30 points to your MIPS final score).

- For small practices with EHR (and not taking the automatic PI hardship exception):
  - Fully report on at least 75% of denominator-eligible patients to meet the data completeness threshold AND with at least 20 patients in the denominator for all quality measures.
  - If not on the EHR 100% the entire year, provide the total eligible patient populations (CMS requires reporting on at least 75% of denominator-eligible patients to meet the data completeness threshold AND with at least 20 patients in the denominator) for all quality measures.
  - The score you need will depend on how well you do in the EHR-based PI category

Improvement activities performance category:

- Complete 1 improvement activity for 90+ consecutive days. The full list of all improvement activities available for reporting in 2026 can be found on the QPP webpage.
- If group reporting, at least 50% of eligible clinicians in your group must complete the same activity in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Promoting interoperability performance category:

- All small practices will receive an automatic PI exemption and have the category reweighted.
- If you accept the automatic PI exemption, the points associated with the PI performance category will be reallocated to the quality and improvement activities performance categories (see reweighting table on page 9). Take into account how this will impact your MIPS final score when deciding whether to accept or decline the automatic PI exemption for small practices
- For practices that plan to submit data for the PI performance category and have certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC), complete the PI required measures and try to maximize your performance where possible.

For those <u>not eligible</u> for the cost performance category (the category is reweighted), do all the following to avoid a penalty (requires a MIPS final score of 75 points).

Quality performance category:

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

- IRIS Registry participants can choose to report via traditional MIPS, the Complete Ophthalmologic Care MIPS Value Pathway (MVP), or both. If submitting through both, CMS will apply the higher scoring submission.

- If you are reporting via traditional MIPS, you are required to report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.

- For practices reporting through the Complete Ophthalmologic Care MVP, you are required to report on 4 quality measures. However, you must select your quality measures from a more limited subset of measures. The subset of measures can be found on the Complete Ophthalmologic Care MVP webpage.

- This category must be performed for the full calendar year on at least 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).

- CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.

- Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

- All small practices that report on at least one quality measure will receive 6 bonus points within the quality category.

- For small practices *without* EHR:

    - Fully report (on at least 75% of denominator-eligible patients and providing the total eligible patient populations for the reporting period AND with at least 20 patients in the denominator) for all quality measures.

    - You must achieve a quality category score of at least 50 out of 100 assuming you are approved for the PI hardship.

- For small practices with EHR (and not taking the automatic PI hardship exception):

  - Fully report (on at least 75% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire reporting period AND with at least 20 patients in the denominator) for all quality measures.

  - The score you need will depend on how well you do in the EHR-based PI category.

Improvement activities performance category:

- Complete 1 improvement activity for 90+ consecutive days. The full list of all improvement activities available for reporting in 2026 can be found on the QPP webpage.

- If group reporting, at least 50% of eligible clinicians in your group must complete the same activity or activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Promoting interoperability performance category:

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

- If you accept the automatic PI exemption, the points associated with the PI performance category will be reallocated to the quality and improvement activities performance categories (see reweighting table on page 9). Take into account how this will impact your MIPS final score when deciding whether to accept or decline the automatic PI exemption for small practices

- For practices that plan to submit data for the PI performance category and have certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC), complete the PI required measures and try to maximize your performance where possible.

Step 5: Choose your measures and/or activities.

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

Quality performance category:

- Performance period: Full calendar year

- Reminder: Unless you receive a hardship exception for the quality performance category, it is not possible to ensure a MIPS final score of 75 points without fully reporting on 6 quality measures (or 4 if reporting through the ophthalmology MVP).

- General Quality Performance Category Information:

- This category must be performed for the full calendar year on 75% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.

    - Report on at least 6 quality measures (or 4 if reporting through the ophthalmology MVP), 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure

    - Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

    - Bonus points: Small Practice Bonus (6 bonus points for the category)

    - All small practices that report on at least one quality measure will receive 6 bonus points within the quality category.

Improvement activities performance category:

- To fulfill the entire improvement activities category score: complete 1 improvement activity for 90+ consecutive days.

- Group Reporting: At least 50% of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.

- CMS can audit each activity you report, so it is recommended that you submit only the required number of activities.

- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the QPP webpage.

- IA_BE_4: Engagement of patients through implementation of new patient portal
    - Implement and provide access to a new patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange
    - Examples include, but are not limited to: brief patient reevaluation by messaging, communication about test results and follow up, and management for any relevant acute or chronic disease management

- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
    - 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.

- IA_EPA_8: Provide Education Opportunities for New Clinicians
    - Act 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.

- IA_BE_25: Drug Cost Transparency
    - Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT)

- IA_BMH_12: Promoting Clinician Well-Being
    - Develop and implement programs to support clinician well-being and resilience through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being

- IA_CC_8: Implementation of documentation improvements for practice/process improvements
    - 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
    - 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).

- IA_EPA_6: Create and Implement a Language Access Plan
    - Create and implement a language access plan to address communication barriers for individuals with limited English proficiency.

Promoting interoperability performance category:

- Performance period: 180+ consecutive days

- This requires the use of certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC),

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

- How CMS Scores the Category:

    - Four PI objectives are required

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

- How to Report Measures:
  - You must submit all required measures or, where available, claim an exclusion to get any PI credit
  - For each performance rate-based measure, you must have at least one patient in the numerator
  - Exclusion for e-Prescribing
    - Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.
  - Exclusion for Query of Prescription Drug Monitoring Program (PDMP)
    - A clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law OR does not electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.
  - Exclusion for Support Electronic Referral Loops by Sending Health Information measure:
    - A clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period
  - Exclusion for Support Electronic Referral Loops by Receiving and Reconciling Health Information measure:
    - A clinician who receives transitions of care or referrals or has patient encounters in which the clinician has never before encountered the patient fewer than 100 times during the performance period

- Exclusion for Immunization Registry Reporting measure:
    - A clinician does not administer any immunizations to any of the populations for which data is collected by their jurisdiction OR operates in a jurisdiction where no immunization registry is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.
- Exclusion for Electronic Case Reporting measure:
    - A clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction OR operates in a jurisdiction where no public health agency is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.

Promoting Interoperability Performance Category Objectives and Measures

Objective	Measures	Reporting requirement	Maximum points
e-Prescribing	e-Prescribing** Query of Prescription Drug Monitoring Program**	Numerator/denominator Yes/No	10 points 10 points
Health-information exchange	Support electronic referral loops by sending health information** Support electronic referral loops by receiving and reconciling health information** OR HIE Bi-Directional Exchange OR Enabling Exchange under TEFCA	Numerator/denominator Numerator/denominator OR Yes/No OR Yes/No	15 points 15 points OR 30 points OR 30 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Numerator/denominator	25 points
Public Health and Clinical Data Exchange	Report the following two measures: Immunization Registry Reporting** and Electronic Case Reporting** Optional measures: Clinical Data Registry reporting,* OR Public Health Registry Reporting, OR Syndromic Surveillance Reporting, OR Public Health Registry Reporting OR Public Health Reporting Using TEFCA	Yes/No	25 points 5 bonus points maximum

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

**Exclusions are available. Check the measure specifications to see if you qualify.

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

STEP 6: Submission

The submission function on the Verana Quality Measures (VQM) Dashboard MIPS Submission tab is activated the January after the end of the performance year. You must review measures, attest, and click the submit button for your information to go to CMS. The Academy and Verana Health will provide reminders of submission deadlines.

Academy and Verana Health Resources:

The Eye on Advocacy news page is updated every Thursday evening and new stories are sent to members by the Washington Report Express email. It is the first place you will see any changes discussed and explained.

Eye on Advocacy	www.aao.org/advocacy/eye-on-advocacy
Academy MIPS Webpages	https://www.aao.org/medicare/mips
EyeNet's MIPS 2026 Resources	https://www.aao.org/eyenet/mips
Email IRIS Registry questions to:	irisdatalink@veranahealth.com for registration, practice-related dashboard, mapping and MIPS submission irisregistry@aao.org for general issues
Email MIPS questions to:	mips@aao.org
AAOE-Talk (for AAOE Members)	https://aao.mobilize.io/users/sign_in/

AMERICAN ACADEMY OF OPHTHALMOLOGY®

2026 Large Practice Roadmap for MIPS

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

Verify your status by using the QPP Participation Status Tool (https://qpp.cms.gov/participation-lookup).

- CMS released the initial eligibility status December 2025 and will release the final eligibility status December 2026.

Clinicians qualify for an automatic exemption from MIPS if they meet one or more of the following criteria:

- New to Medicare for 2026 and hasn't previously submitted claims under Medicare
- Less than or equal to $90,000 in Medicare Part B service allowed charges
- Provides covered professional services to 200 or fewer Medicare Part B patients
- Provides 200 or fewer covered professional services to Part B patients. When you treat more than 200 patients you are, by definition, performing at least 200 services
- Clinician is a qualifying participant in an Advanced Alternative Payment Model.

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

- October 1, 2024 – September 30, 2025, and/or
- October 1, 2025 - September 30, 2026

Please note that if the clinician is reporting as a part of a group, the low-volume threshold is evaluated at the group level

Step 2. Are You in a Large Practice?

A large practice is defined as 16 or more eligible clinicians. If you are in a small practice, please refer to the Small Practice Roadmap on page 10.

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

Goal	Effect on Reimbursement	MIPS Final Score Required
Avoid the maximum 9% Penalty	Avoids the full 9% penalty on your 2028 Medicare Part B services reimbursements. (Between 18.76 and 74.99 points, the penalty is on a sliding scale, ranging from approximately 6.75% - 0.01%)	18.76 points
Avoids a penalty	Avoids a penalty on your 2028 Medicare Part B services reimbursements	75 points
Small bonus	Qualifies you for a small bonus on your 2028 Medicare Part B services reimbursements	Above 75 points

Step 4. How to Achieve Your Goal for the 2026 Performance Year

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

MIPS Performance Category	2026 Score Default Weight
Quality	30%
Promoting interoperability	25%
Improvement activities	15%
Cost	30%

To Avoid a Penalty (requires a MIPS final score of 75 points), do the following:

Quality performance category:

- IRIS Registry participants can choose to report via traditional MIPS, the Complete Ophthalmologic Care MIPS Value Pathway (MVP), or both. If submitting through both, CMS will apply the higher scoring submission.

- If you are reporting via traditional MIPS, you are required to report on at least 6 quality measures, 1 of which must be an outcome or, if no outcome measure is available, another type of high priority measure.

- For practices reporting through the Complete Ophthalmologic Care MVP, you are required to report on 4 quality measures. However, you must select your quality measures from a more limited subset of measures. The subset of measures can be found on the Complete Ophthalmologic Care MVP webpage.

- This category must be performed for the full calendar year on at least 75% of denominator-eligible patients to meet the data completeness threshold AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure).

- CMS emphasizes that 100% of eligible patients is desired for MIPS reporting. If you are NOT submitting 100% of all eligible patients, you must provide your total eligible population to verify that you meet the data completeness threshold.

- Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

Improvement activities performance category:

- Complete 1 improvement activity for 90+ consecutive days. The full list of all improvement activities available for reporting in 2026 can be found on the QPP webpage.

- If group reporting, at least 50% of eligible clinicians in your group must complete the same activity or activities in any continuous 90-day period. The clinicians do not need to share the same 90-day period.

Promoting interoperability performance category:

- With certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC), complete the PI required measures and try to maximize your performance where possible.

Step 5: Choose your measures and/or activities.

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

Quality performance category:

- Performance period: Full calendar year
- Reminder: Unless you receive a hardship exception for the quality performance category, it is not possible to ensure a MIPS final score of 75 points without fully reporting on 6 quality measures (or 4 if reporting through the ophthalmology MVP).
- General Quality Performance Category Information:
- This category must be performed for the full calendar year on 75% of denominator-eligible patients to meet the data completeness threshold and providing the total eligible patient populations if not reflective of the entire calendar year AND at least 20 patients in the denominator for each measure AND a performance rate >0% (or <100% if an inverse measure). CMS emphasizes that 100% of eligible patients is desired for MIPS reporting.
    - Report on at least 6 quality measures (or 4 if reporting through the ophthalmology MVP), 1 of which must be an outcome measure or, if no outcome measure is available, another type of high priority measure
    - Review the benchmark summaries on page 46 to make sure your choices maximize your point potential.

Improvement activities performance category:

- To fulfill the entire improvement activities category score: complete 2 improvement activities for 90+ consecutive days.
- Group Reporting: At least 50% of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.
- CMS can audit each activity you report, so it is recommended that you submit only the required number of activities.
- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the QPP webpage.
- To fulfill the entire improvement activities category score: complete 1 improvement activity for 90+ consecutive days.

- Group Reporting: At least 50% of the group's clinicians need to perform the same IA(s) for the whole group to get credit. The clinicians performing the IA(s) do not all need to perform it on the same 90+ consecutive day period for the group to get credit.

- CMS can audit each activity you report, so it is recommended that you submit only the required number of activities.

- The following are improvement activities that many clinicians/practices already do routinely. Read the activity specifications available on the QPP webpage.

- IA_BE_4: Engagement of patients through implementation of new patient portal
    - Implement and provide access to a new patient/caregiver portal that allows users (patients or caregivers and their clinicians) to engage in bidirectional information exchange
    - Examples include, but are not limited to: brief patient reevaluation by messaging, communication about test results and follow up, and management for any relevant acute or chronic disease management

- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
    - 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.

- IA_EPA_8: Provide Education Opportunities for New Clinicians
    - Act 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.

- IA_BE_25: Drug Cost Transparency
    - Provide counseling to patients and/or their caregivers regarding: costs of medications using a real time benefit tool (RTBT)

- IA_BMH_12: Promoting Clinician Well-Being
    - Develop and implement programs to support clinician well-being and resilience through relationship-building opportunities, leadership development plans, or creation of a team within a practice to address clinician well-being

- IA_CC_8: Implementation of documentation improvements for practice/process improvements
    - 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

    - 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).

- IA_EPA_6: Create and Implement a Language Access Plan
    - Create and implement a language access plan to address communication barriers for individuals with limited English proficiency.

Promoting interoperability performance category:

- Performance period: 180+ consecutive days
- This requires the use of certified electronic health record technology (CEHRT) that meets certification criteria defined by the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator for Health IT (ONC),
    - Note: You can only report data that is captured by CEHRT for this category. If you report as a group, you will not be downgraded if not all your clinicians use CEHRT.
- How CMS Scores the Category:
    - Four PI objectives are required
    - To receive any credit for the category, you must meet the reporting requirements or, where available, claim an exclusion, for all the required measures
    - Some of these measures will be scored based on your performance rate
    - Some measures are optional bonus measures
    - Critical attestations. To score more than 0%, you must submit "Yes" for:
        - The Security Risk Analysis attestations
        - The SAFER Guides attestation
        - The Prevention of Information Blocking attestation
        - The ONC Direct Review attestation
- How to Report Measures:
    - You must submit all required measures or, where available, claim an exclusion to get any PI credit
    - For each performance rate-based measure, you must have at least one patient in the numerator
    - Exclusion for e-Prescribing

- Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

- Exclusion for Query of Prescription Drug Monitoring Program (PDMP)
  - A clinician is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law OR does not electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.

- Exclusion for Support Electronic Referral Loops by Sending Health Information measure:
  - A clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period

- Exclusion for Support Electronic Referral Loops by Receiving and Reconciling Health Information measure:
  - A clinician who receives transitions of care or referrals or has patient encounters in which the clinician has never before encountered the patient fewer than 100 times during the performance period

- Exclusion for Immunization Registry Reporting measure:
  - A clinician does not administer any immunizations to any of the populations for which data is collected by their jurisdiction OR operates in a jurisdiction where no immunization registry is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data as of 6 months prior to the start of the performance period.

- Exclusion for Electronic Case Reporting measure:
  - A clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction OR operates in a jurisdiction where no public health agency is capable of accepting the data in the specific standards required to meet the CEHRT definition OR operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.

Promoting Interoperability Performance Category Objectives and Measures

Objective	Measures	Reporting requirement	Maximum points
e-Prescribing	e-Prescribing** Query of Prescription Drug Monitoring Program**	Numerator/denominator Yes/No	10 points 10 points
Health-information exchange	Support electronic referral loops by sending health information** Support electronic referral loops by receiving and reconciling health information** OR HIE Bi-Directional Exchange OR Enabling Exchange under TEFCA	Numerator/denominator Numerator/denominator OR Yes/No OR Yes/No	15 points 15 points OR 30 points OR 30 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	Numerator/denominator	25 points
Public Health and Clinical Data Exchange	Report the following two measures: Immunization Registry Reporting** and Electronic Case Reporting** Optional measures: Clinical Data Registry reporting,* OR Public Health Registry Reporting, OR Syndromic Surveillance Reporting, OR Public Health Registry Reporting OR Public Health Reporting Using TEFCA	Yes/No	25 points 5 bonus points maximum

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

** Exclusions are available. Check the measure specifications to see if you qualify.

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

STEP 6: Submission

The submission function on the Verana Quality Measures (VQM) Dashboard MIPS Submission tab is activated the January after the end of the performance year. You must review measures, attest, and click the submit button for your information to go to CMS. The Academy and Verana Health will provide reminders of submission deadlines.

Academy and Verana Health Resources:

The Eye on Advocacy news page is updated every Thursday evening and new stories are sent to members by the Washington Report Express email. It is the first place you will see any changes discussed and explained.

Eye on Advocacy	www.aao.org/advocacy/eye-on-advocacy
Academy MIPS Webpages	https://www.aao.org/medicare/mips
EyeNet's MIPS 2026 Resources	https://www.aao.org/eyenet/mips
Email IRIS Registry questions to:	irisdatalink@veranahealth.com for registration, practice-related dashboard, mapping and MIPS submission irisregistry@aao.org for general issues
Email MIPS questions to:	mips@aao.org
AAOE-Talk (for AAOE Members)	https://aao.mobilize.io/users/sign_in/