MIPS Program: 2022 Quality Performance Category

Quality Category Weight – 30%

For 2022, CMS will weight a provider's Quality performance score at 30% of the overall MIPS final score.

CMS is statutorily required to weigh the cost and quality performance categories equally beginning with Performance Year 2022, and as such, the Quality category will be weighted at 30% for performance year 2022. If a physician or group does not have any cost measures attributed, the weight of the Cost category is transferred to Quality.

In some cases, CMS may determine that a provider is excluded from one or more of the other MIPS categories and will re-weight the individual provider's quality performance score to make up the difference.

CMS will continue to use historical benchmarks to score quality measures for the 2022 performance period. Performance period benchmarks will still be calculated for new quality measures or when comparable data from the baseline period is not available.

For 2022, a total of 200 MIPS quality measures were finalized, including 1 new administrative claims based measure.

Quality Category Performance Period

In 2022, physicians and groups must submit quality measure data for the full calendar year to be considered full participants in the MIPS program.

Quality Reporting Requirements

Physicians must report on 70% of all patients, if reporting via registry or EHR, and 70% of Medicare Part B patients if reporting via claims. CMS will maintain the current data completeness threshold at 70% for the 2022 and 2023 performance periods.

There are 3 quality measures that will be automatically evaluated and calculated through administrative claims, if the case minimum requirements are met:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinicians Groups.
- Risk-standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS).
- NEW: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure OR a high priority measure, if an outcome is not available. High priority measures are certain CMS designated measures that include all outcome measures. Groups can report on all 10 CMS Web interface measures **(groups only).**

In 2022, CMS will continue to measure a physician's improvement on quality measures prior to the previous year. Physicians have the opportunity to earn up to 10 additional points, not to exceed the 60 or 70 total available points in the category, from year-to-year improvement in the Quality category.

Topped-Out Measures

After determining that several ophthalmology measures—predominantly those reported via claims—have been "topped out" for multiple years, meaning that overall performance is consistently high, **CMS began capping the total possible points for these measures at seven points in 2019, instead of the usual ten possible points per measure.** Therefore, if a physician or group reports only capped measures, that physician or group cannot earn the full available points for the category. This impacts nearly all ophthalmology measures, as well as many for other specialties, reported via claims and some reported via registry and EHR.

ASCRS and the medical community have consistently opposed the topped-out measure methodology and argued that physicians should continue to receive full credit for maintaining high quality. We will continue to work with the medical community to address this issue.

Multiple Submission Methods

CMS allows physicians to submit measures through multiple submission types. Physicians and groups may select any six measures and submit them through a variety of options. For example, a physician may report four measures through claims, but meet the full required six by submitting two more through registry. In addition, for measures that have multiple submission options, the physician or group may submit through both mechanisms, and CMS will include whichever one has the highest score in the final category score. **If physicians or groups use a submission type that has fewer than six measures they can report, they are not required to identify other measures in an additional submission mechanism to make up the full six measures.**

Transition Period Scoring Consideration

Small practices of 15 or fewer eligible clinicians will receive 3 points on quality measures that don't meet data completeness, while non-small practices of 16 or more eligible clinicians will receive 0 points. Small practices would still receive a 6 point bonus added to the Quality performance score, as long as one quality measure is submitted.

Quality Achievement Score

Under MIPS, **providers must demonstrate achievement on a quality measure, relative to a benchmark performance. For the 2022 performance year, CMS will set a baseline performance benchmark for each measure based on historical performance data. A physician's benchmark score on each measure is known as the "achievement" score. The achievement score will be added to any improvement or bonus points to determine the category score.**

For 2022, each measure has specific benchmarks depending on submission method (i.e., claims, EHR, registry) that are scored on a decile, or 10-point, scale. For each submission method, CMS has assigned different levels of performance to each decile. Each decile is a range of performance levels for the measure that correspond to points earned for the measure. For example, if a physician submits data showing 83% performance on a measure, and the 5th decile begins at 72% performance and the 6th decile begins at 85% performance, then he or she will receive between 5 and 5.9 points because 83% is in the 5th decile. If a physician or group has submitted a measure through multiple submission mechanisms, CMS will use whichever score is highest toward the achievement score.

The total possible achievement score in the Quality category depends on the size of the practice:

- Providers in groups of 15 or fewer eligible clinicians are subject to 6 measures and are eligible to receive up to
  60 points in the Quality performance category.
- Providers in groups of 16 or more are subject to 9 measures (6 to be reported, and 3 administrative claims-base measures).
- CMS also finalized an additional new administrative claims measure: **Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.**
- If the individual, group, or virtual group does not meet the case minimum and clinician requirement for the new measures, they will not be calculated, and providers will only be scored on the reported 6 measures, for a total possible score of 60 points.

Scoring updates will be applied to new measures and measures that do not meet case minimum and data completeness requirements, and measures that do not have a benchmark.

- New quality measures will have a 7-point floor for their first year in the program, and a 5-point floor for their second year in the program.
  - In their first year, new measures will earn 7 points if no benchmark can be created, provided the case minimum and data completeness are met.
  - In their second year, these measures will earn 5 points if no benchmark can be created, provided the case minimum and data completeness are met.
- New measures that can be scored against a benchmark will earn 5 – 10 points.

CMS will only calculate a group-level quality score from Medicare Part B claims reported by a small practice if they also report group-level data in another performance category.

Note: Beginning in performance year 2023, quality measures that don't have a benchmark or meet the case minimum will earn 0 points (small practices will continue to earn 3 points). **Beginning in performance year 2023**, quality measures that can be scored against a benchmark will be eligible for 1 – 10 points.

Quality Improvement Score

For 2022 performance, CMS will also calculate a physician's or group's quality improvement score. Because physicians have the option of choosing which quality measures to report and are not required to report the same measures from year to year, CMS is evaluating improvement on a category basis.

CMS will compare a physician's total 2021 achievement score, which is determined based on the physician's performance relative to the benchmarks and excludes any bonus points and compare it to the

2022 achievement score. CMS will award between 1 and 10 percentage points, up to the total 60 or 70 available for the category, depending on how much a physician's or group's achievement score improved above the prior year.

The improvement score is derived by:

- **The increase in quality achievement percent score from prior performance period to current performance period**
- **Divided by prior performance period quality achievement percentscore**
- **Multiplied by 10%**

Improvement scores cannot be less than zero points, and thus a physician who earns a lower achievement score in the current performance period than the prior one will not be penalized.

CMS will only calculate improvement scores in 2022 for physicians and groups who participated fully in the Quality category in 2021 and earned at least 30% of available points in the Quality category.

Bonus Points

Beginning with performance year 2022, CMS will remove bonus points for reporting additional outcome and high-priority measures, beyond the one required.

Also beginning with performance year 2022, CMS will remove bonus points for measures that meet end-to-end electronic reporting criteria.

Six bonus points will still be added to the quality performance category score for clinicians in small practices who submit at least 1 measure, either individually or as a group or virtual group. This bonus isn't added to clinicians or groups who are scored under facility-based scoring.

Clinicians may also earn up to 10 additional percentage points based on your improvement in the quality performance category from the previous year.

Small Practice Bonus

In 2019, CMS moved the small practice bonus—which had previously been added to the MIPS final score—to the Quality category and will continue this policy for 2022. For 2022, 6 bonus points will be added to the Quality category score of any small practice, as long as one quality measure is submitted.

Similar to the other bonuses discussed above, small practice bonus points will only be awarded up to the total 60 points available for the category.

Global and Population Measures

There are 3 quality measures that will be automatically evaluated and calculated through administrative claims, if the case minimum requirements are met:
• Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinicians Groups.

• Risk-standardized Complication Rate (RSCR) Following Electric Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS).
• **NEW: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Condition**

Physicians do not need to report on these measures; CMS will score them based on administrative claims.

Data Submission

Physicians and groups may report their quality performance data through claims, registry, EHR, or Web Interface (only available for groups of 25 or more).

Physicians or groups do not need to use the same submission mechanism for every category.

If clinicians submit any data as an individual, they'll be evaluated for all performance categories as an individual. If your practice submits any data as a group, you'll be evaluated for all performance categories as a group. If data is submitted both as an individual and a group, you'll be evaluated as an individual and as a group for all performance categories, but your MIPS payment adjustment will be based on the higher score.

Beginning with the 2022 performance year, CMS will only calculate a group-level quality performance category score from Medicare Part B claims measures if the practice submits data from another category as a group (signaling their intent to participate as a group).

2022 MIPS Quality Category Measures for Ophthalmology

Physicians must report on 70% of all patients, if reporting via registry or EHR, and 70% of all Medicare Part B patients if reporting via claims.

Physicians must report a minimum of 6 measures, with at least one being an outcome measure OR a high priority measure, if an outcome is not available. High priority measures are certain CMS designated measures that include all outcome measures. Groups can report on all 10 CMS Web interface measures (groups only).

Note: Beginning in performance year 2023, quality measures that don't have a benchmark or meet the case minimum will earn 0 points (small practices will continue to earn 3 points). Also beginning in the 2023 performance period, measures will earn between 1 and 10 achievement points if they can be scored against a benchmark.

NQF/Quality Number	Submission Mechanism	Measure Type	Measure Domain	Measure Title
0086/012	EHR	Process	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
0087/014	Registry	Process	Effective Clinical Care	Age-Related Macular Degeneration (AMD): Dilated Macular Examination
0089/019	Registry, EHR	Process	Communication and Care Coordination **(high priority)**	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
0055/117	Claims, Registry, EHR	Process	Effective Clinical Care	Diabetes: Eye Exam
0419/130	Claims, Registry, EHR	Process	Patient Safety **(high priority)**	Documentation of Current Medications in the Medical Record
0563/141	Claims, Registry	Outcome	Communication and Care Coordination **(high priority)**	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% or Documentation of a Plan of Care

0565/191	Registry, EHR	Outcome	Effective Clinical Care **(high priority)**	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
0028/226	Claims, Web Interface,Registry, EHR	Process	Community/Population Health	Preventative Care and Screening: Tobacco Use: Screening and Cessation Information
0022/238	Registry, EHR	Process	Patient Safety **(high priority)**	Use of High-Risk Medications in Older Adults
N/A/303	Registry	Patient Reported Outcome-Based	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
N/A/304	Registry	Patient Reported Outcome-Based	Person Caregiver-Centered Experience and Outcomes **(high priority)**	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
N/A/374	EHR, Registry	Process	Communication and Care Coordination **(high priority)**	Closing the Referral Loop: Receipt of Specialist Report
N/A/384	Registry	Outcome	Effective Clinical Care (high priority)	Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room within 90 Days of Surgery
N/A/385	Registry	Outcome	Effective Clinical Care (high priority)	Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement within 90 Days of Surgery
N/A/389	Registry	Outcome	Effective Clinical Care (high priority)	Cataract Surgery: Difference Between Planned and Final Refraction

Other Available Measures

CMS continues not to require that one of the quality measures be a cross-cutting measure. However, measures that are deemed cross-cutting are still available for physicians to report.

NQF/PQRS Number	Submission Method	Measure Type	Measure Domain	Measure Title
0018/236	Claims, Web Interface, Registry, EHR	Intermediate Outcome* **(high priority)**	Effective Clinical Care	Controlling: High Blood Pressure

*Intermediate outcome measures are considered outcome measures.

Ophthalmology Quality Measure Benchmarks

Each decile includes a range of performance rates. Deciles without benchmarks (denoted by a --) indicate that there are no scores available in that decile.

Measure Name	PQRS Number	Reporting Method	Seven Point Cap	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	12	EHR	No	79.71 - 86.73	86.74 - 91.38	91.39 - 94.84	94.85 - 96.83	96.84 - 98.25	98.26 - 99.16	99.17 - 99.88	>= 99.89
Age-Related Macular Degeneration (AMD): Dilated Macular Examination	14	Registry	**Yes**	88.05 - 92.58	92.59 - 95.84	95.85 - 97.86	97.87 - 99.33	99.34 - 99.99	--	--	100

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	EHR	No	62.50 - 72.40	72.41 - 80.36	80.37 - 85.82	85.83 - 90.31	90.32 - 93.70	93.71 - 96.86	96.87 - 99.02	>= 99.03
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	19	Registry	**Yes**	79.11 - 90.90	90.91 - 96.91	96.92 - 99.64	99.65 - 99.99	--	--	--	100
Diabetes: Eye Exam	117	EHR	No	13.19- 22.02	22.03 - 31.85	31.86 - 44.61	44.62 - 65.96	65.97 - 95.93	95.94 - 99.13	99.14 - 99.99	100
Diabetes: Eye Exam	117	Claims	**Yes**	--	--	--	--	--	--	--	100
Diabetes: Eye Exam	117	Registry	**Yes**	94.31 - 97.85	97.86 - 99.32	99.33 - 99.85	99.86 - 99.99	--	--	--	100
Documentation of Current Medications in the Medical Record	130	EHR	**Yes**	80.38 - 88.23	88.24 - 92.35	92.36 - 95.25	95.26 - 97.16	97.17 - 98.41	98.42 - 99.32	99.33 - 99.89	>= 99.90
Documentation of Current Medications in the Medical Record	130	Claims	**Yes**	99.67 - 99.96	99.97 - 99.99	--	--	--	--	--	100
Documentation of Current Medications in the Medical Record	130	Registry	**Yes**	77.92 - 90.46	90.47 - 95.59	95.60 - 98.14	98.15 - 99.68	99.69 - 99.99	--	--	100
Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Claims	No	96.44	--	--	--	--	--	--	100

Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	141	Registry	No	46.38 - 69.02	69.03 - 81.81	81.82 - 90.43	90.44 - 95.41	95.42 - 98.27	98.28 - 99.99	--	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	EHR	No	88.67 - 93.01	93.02 - 95.34	95.35 - 96.82	96.83 - 97.96	97.97 - 98.80	98.81 - 99.63	99.64 - 99.99	100
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	191	Registry	No	92.83 - 95.51	95.52 - 97.32	97.33 - 98.54	98.55 - 99.99	--	--	--	100
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Claims	No	--	--	--	--	--	--	--	--
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	EHR	No	--	--	--	--	--	--	--	--
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	226	Registry	No	--	--	--	--	--	--	--	--
Controlling High Blood Pressure	236	Claims	No	20 - 29.99	30 - 39.99	40 - 49.99	50 - 59.99	60 - 69.99	70 - 79.99	80 - 89.99	>= 90
Controlling High Blood Pressure	236	Registry	No	20 - 29.99	30 - 39.99	40 - 49.99	50 - 59.99	60 - 69.99	70 - 79.99	80 - 89.99	>= 90
Controlling High Blood Pressure	236	EHR	No	51.06 - 56.30	56.31 - 60.13	60.14 - 63.63	63.64 - 67.04	67.05 - 70.64	70.65 - 74.94	74.95 - 80.83	>= 80.84

Use of High-Risk Medications in Older Adults	238	Registry	No	--	--	--	--	--	--	--	--
Use of High-Risk Medications in Older Adults	238	EHR	No	--	--	--	--	--	--	--	--
Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	303	Registry	No	--	--	--	--	--	--	--	--
Cataracts: Patient Satisfaction within 90 Days	304	Registry	No	--	--	--	--	--	--	--	--
Closing the Referral Loop: Receipt of Specialist Report	374	EHR	No	7.71 - 12.49	12.50 - 18.72	18.73 - 26.31	26.32 - 37.09	37.10 - 51.18	51.19 - 66.66	66.67 - 87.31	>= 87.32
Closing the Referral Loop: Receipt of Specialist Report	374	Registry	No	62.79 - 85.63	85.64 - 94.75	94.76 - 98.61	98.62 - 99.99	--	--	--	100
Adult Primary Rhegmatogenous Retinal Detachment Surgery: No Return to the Operating Room Within 90 Days of Surgery	384	Registry	No	93.33 - 96.42	96.43 - 97.91	97.92 - 99.99	--	--	--	--	100
Adult Primary Rhegmatogenous Retinal Detachment Surgery: Visual Acuity Improvement Within 90 Days of Surgery	385	Registry	No	--	--	--	--	--	--	--	--
Cataract Surgery: Difference Between Planned and Final Refraction	389	Registry/QCDR	No	21.48 - 29.53	29.54 - 39.34	39.35 - 69.93	69.94 - 92.85	92.86 - 97.13	97.14 - 99.86	99.87 - 99.99	100