# **2024 MIPS Peer-Reviewed Journal Article Requirement Template**

Section 101(c)(1) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires submission of new measures for publication in applicable specialty-appropriate, peer-reviewed journals prior to implementing in the Merit-based Incentive Payment System (MIPS). Such measures will be submitted by the Centers for Medicare & Medicaid Services (CMS), to a journal(s), before including any new measure on the MIPS Quality Measures List. The measure submitter shall provide the required information for article submission under the MACRA per the MIPS Annual Call for Quality Measures submission process.

Interested parties submitting measures for consideration through the MIPS Annual Call for Quality Measures must complete the required information by the CMS Annual Call for Measures deadline (8 p.m. ET on May 10, 2024). Some of the information requested below may be listed in specific fields in the CMS Measures Under Consideration (MUC) Entry/Review Information Tool (MERIT); however, to ensure that CMS has all of the necessary information and avoid delays in the evaluation of your submission, please fully complete this form as an attached Word document. The information in MERIT must be consistent with the information below, including the following, but not limited to:

* **[Measure Title] Assessment of Autonomic Dysfunction and Follow-up**
* **[Meaningful Measures 2.0 Framework Domain] Chronic conditions**

**Measure Steward:** [Name] American Academy of Neurology

**Measure Developer:** [Name] American Academy of Neurology

**Description:** [Text] Percentage of patients with a diagnosis of Parkinson’s disease (or caregivers as appropriate) who were assessed for symptoms or signs of autonomic dysfunction once in the past 12 months, and if autonomic dysfunction was identified, patient had appropriate follow-up.

## **Statement**

* Background (Why is this measure important?).

Parkinson’s disease (PD) is the second most common neurodegenerative disorder. Age is the most consistent risk factor for PD, which is uncommon below the age of 50 and peaks in both prevalence and incidence in the 9th decade. Globally, the overall prevalence of PD in 2016 was 6.1 million. In the United States, there were an estimated 680,000 cases of PD among individuals aged ≥45 years in 2010. This number was projected to rise to 930,000 cases in 2020 and double to 1,238,000 cases by 2030.

Clinically, PD is characterized by both motor (rest tremor, bradykinesia, rigidity) and non-motor (including but not limited to neuropsychiatric, autonomic, and sensory) symptoms. Dopaminergic neuron loss and α-synuclein-containing Lewy bodies are seen in the substantia nigra pathologically. While there are effective symptomatic treatments for the major motor symptoms of PD, there are currently no proven therapies to modify disease progression. Symptom burden increases as the disease advances, and PD is now the fastest growing source of neurological disability worldwide. Estimated direct medical expenses for the PD population were approximately $14.4 billion in 2010, $8.1 billion more than the estimate for the general population without PD, with the majority of costs going towards nursing home care. The estimated indirect nonmedical cost of PD, which includes work days lost, disability payments and home health care costs, was estimated to be $6.3 billion in 2010iv. This economic burden will only grow in the coming years as the population ages and the number of people with PD increases.

* Environmental scan (Are there existing measures in this area?). No existing measures known.

## **Gap Analysis**

* Provide evidence for the measure (What are the gaps and opportunities to improve care?).

Autonomic dysfunction was found to be the most prevalent non-motor symptoms of PD, affecting more than 70% of patients in all stages of PD. Non-motor challenges may become the chief therapeutic challenge in advanced stages of PD, and many may not have effective treatment options. In a two-year study, development of symptoms in the cardiovascular, apathy, urinary, psychiatric, and fatigue domains was associated with significant worsening quality of life.

In a 2013 study by Baek et al., reviewing compliance with quality measure recommendations, it was noted that provider compliance rate for annual review of autonomic dysfunction was 22.8%. Martello et al. reported that compliance with this measure in a Movement Disorders Center was 83%, suggesting a difference in compliance between general neurologists and movement disorders specialists.

The following screening tools are not inclusive, but may be helpful for use in practice:

· Scales for Outcomes in Parkinson’s disease – Autonomic (SCOPA-AUT)

* Expected outcome (patient care/patient health improvements, cost savings).

Address and eliminate symptoms and improve quality of life.

* Recommendation for the measure (Is it based on a study, consensus opinion, USPSTF recommendation etc.?). Guideline

## **Reliability/Validity**

* What testing has been performed at the level of implementation? (MIPS requires full measure testing at the individual clinician level (and may also need to be tested at the group level) for MIPS Clinical Quality Measures (CQMs) and Electronic Clinical Quality Measures (eCQMs) collection types. Administrative claims measures tested at the group level require a reliability threshold to be implemented at the group level.)

Please provide testing results including the N value, Bonnie test case results, correlation coefficient and any other pertinent information or values to be considered.

* + Reliability Testing Results at the accountable entity level The AAN used signal-to-noise reliability analysis for this measure at the individual clinician level. The sample size was 163 and the result was 0.96. This was calculated using a beta-binomial model.
  + Face Validity Testing Results, Clinician Sites The AAN conducted a face validity survey of clinician experts. The sample size was 18, and 15 voted in agreement that the measure could differentiate good from poor quality care.
  + Empiric Validity Testing Results at the accountable entity level The AAN conducted empiric validity at the individual clinician level using a correlation analysis. The sample size was 149 and the correlation coefficient was 0.3815 (p-value < 0.0001); r-squared value: 0.1455.
  + Data Element/Patient Encounter Level Testing The AAN conducted patient encounter level testing through an 8 & 30 review. The sample size was 8 encounters and there was 100% agreement.
  + Exclusion Frequency
  + What were the minimum sample sizes used for reliability results? Sample size was 163.
  + Other Information
* Is it risk adjusted? No If so, how?
* What benchmarking information is available?
* Collection Type: Specify the data collection type. Clinical registries and electronic health record data.
* Specify measure stage of development. Measure use, continuing evaluation & maintenance
* For Patient Reported Outcome Performance Measures:
  + The survey or tool has been tested and doesn’t require modifications based on results?
  + Patient/encounter level testing for each critical data element doesn’t require changes to the tool base on the results?

## **Endorsement**

* Provide the Consensus-Based Entity (CBE) (i.e., Partnership for Quality Measures (PQM)) endorsement status (and CBE ID) and/or other endorsing body. If the measure is only endorsed for paper records, please note endorsement for only the data source being submitted. Not endorsed. Will submit for endorsement in next available cycle.

## **Summary**

* Alignment with CMS Meaningful Measures Initiative or MACRA (if applicable). Chronic conditions
* Relevance to MIPS or other CMS programs.

This measure is currently being used in the American Academy of Neurology’s Axon Registry. It has been approved by CMS for use since 2017 as AAN 9. The AAN’s QCDR is shutting down operations as of June 1, 2024. The AAN is seeking to submit this measure through the MUC process so neurologists and other clinicians may maintain access to neurology-specific measures.

Additionally, this measure is currently being used in MIPS MVP: Supportive Care for Neurodegenerative Conditions. This measure cannot be used in the MVP after the Axon Registry shuts down. AAN is submitting this measure through the MUC process to maintain continuity in reporting options.

* Rationale: Use of measure for inclusion in program (specialty society, regional collaborative, other).

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* Public reporting (if applicable).
* Preferable relevant peer-reviewed journal for publication. *Neurology*
* Rationale as to how the measure correlates to existing cost measures and improvement activities, as applicable and feasible.

Neurology currently has one cost measure for stroke inpatient care. There are no relevant cost measures.

Relevant Improvement Activities include:

* IA\_PM\_13: Chronic care and preventative care management for empaneled patients
* IA\_PM\_5: Engagement of community for health status improvement
* IA\_BE\_15: Engagement of patients, family, and caregivers in developing a plan of care
* IA\_BE\_22: Improved practices that engage patients pre-visit
* IA\_BE\_23: Integration of patient coaching practices between visits
* IA\_BE\_16: Promote self-management in usual care
* IA\_BE\_12: Use evidence-based decision aids to support shared decision-making
* IA\_BE\_1: Use of certified EHR to capture patient reported outcomes