# **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] Patient reported falls and plan of care**
* **[Meaningful Measures 2.0 Framework Domain] Safety**

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

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

**Description:** [Text] Percentage of patients (or caregivers as appropriate) with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall occurred and those that fell had a plan of care for falls documented at every visit.

## **Statement**

* Background (Why is this measure important?). Many studies have been conducted on the rate of falls for common neurological conditions. All of them indicate that falls are an issue for neurology patients with symptomology that affects movement and balance. Falls and the fear of falling can impact quality of life and should be addressed for populations most at risk for falling.

In people aged 65 years and older, falls are one of the leading causes of death. However, patients with neurological conditions are often younger and are at an increased risk for falls due to disease symptomology. 127,456,106 non-fatal falls were recorded from 2001 to 2015. For those that were hospitalized due to the fall, the cost is approximately $39,000 per patient.

The U.S. Preventive Services Task Force updated their recommendations for fall prevention in community-dwelling older adults. There are many intervention recommendations for patients 65 years and older.

* Environmental scan (Are there existing measures in this area?). This is a variation of the NCQA measure (NQF# 0101). A separate measure is needed to capture the wider age range of neurology patients that often experience falls earlier in life due to their decreased motor function. The AAN has talked with NCQA about adjusting the denominator of their measure to capture the younger neurology population. This was not possible as treatment plans for those over 65 vary from the treatment plan for those younger. As such, a separate measure is necessary.

## **Gap Analysis**

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

In people aged 65 years and older, falls are one of the leading causes of death. However, patients with neurological conditions are often younger and are at an increased risk of falling due to their disease symptomology. 127,457,106 non-fatal falls were recorded from 2001 to 2015. For those that were hospitalized due to the fall, the cost is approximately $39,000 per patient.

There is evidence that vitamin D supplementation may play a role in preventing falls or preventing fractures. However, there is not enough evidence to support it for all neurological patients at this time.

* Expected outcome (patient care/patient health improvements, cost savings). Lessen or eliminate falls.
* Recommendation for the measure (Is it based on a study, consensus opinion, USPSTF recommendation etc.?). Guideline, systematic review, and empiric data

## **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 for Part A was 190 and 138 for Part B. The result for Part A was 0.98 and 1.00 for Part B. 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 8, and 6 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 testing at the individual clinician level by using a correlation analysis. The sample size for Part A was 157 and 127 for Part B. The correlation coefficient for Part A was -0.0665 (p-value=0.4080); r-squared value: 0.0044. Part B correlation coefficient was -0.2324 (p-value=0.0086); r-squared value: 0.0540.
  + 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 190 for Part A and 138 for Part B.
  + 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). Safety
* 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 2021 as AAN 34. 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 MPV 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
* IA\_PSPA\_21: Implementation of a fall screening and assessment programs