

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] Person-Centered Outcome - Goal Identification**
- **[Meaningful Measures 2.0 Framework Domain] Person-Centered Care**

Measure Steward: National Committee for Quality Assurance

Measure Developer: National Committee for Quality Assurance

Description: The percentage of individuals 18 years of age and older with a complex care need who had a person-centered outcome goal identified resulting in completion of goal attainment scaling (GAS) or patient reported outcome measure (PROM) and development of an action plan.

I. Statement

- Background/Environmental Scan

There is broad agreement that individuals' priorities and goals should guide their health care, particularly for adults with complex care needs (i.e., multiple chronic conditions and functional limitations) (American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012). For these individuals, there is a growing movement to provide goal-based care. Goal-based care, rooted in person-centered goals, includes clinicians eliciting personal goals and preferences and engaging with their patients and caregivers in shared decision-making to develop a care or treatment plan that will help support the achievement of those goals. (Blaum et al., 2018; Elwyn & Vermunt, 2019; Jennings et al., 2018; Naik et al., 2018; Tinetti et al., 2012, 2019). There is growing evidence that supports the use of person-centered care with personalized goal setting in different patient populations. Goal setting has been linked to more positive outcomes and improvements in health and functioning in a variety of populations, such as those with rehabilitation needs (Kang et al., 2022; Barnett et al. 2023), those with dementia (Chenoweth et al., 2022; Budgett et al., 2024), and those with mental or behavior disorders (Choy-Brown et al., 2020; Lee et al., 2022; Shimin et al., 2023).

The Centers for Medicare and Medicaid Services (CMS) support aligning care with patients' goals as demonstrated by the "Meaningful Measures" initiative, which calls for quality measures where "care is personalized and aligned with patient's goals". NCQA has taken steps to develop quality measures focusing on goal-based care. This person-centered outcome-goal identification measure is a pioneering measure in the goal-based care realm.

II. Gap Analysis

- The measure is intended to be used at the clinician group level. We tested this measure in different settings: primary care/LTSS setting and CCBHCs, in total 10 testing sites. While the average and the median of the performance were high (avg. 75.13%; p50=89.5%) across 10 testing sites. However, we observed a big variation (STD 31.14%) in the performance across different settings. The performance in the primary care/LTSS setting is lower compared to CCBHCs (average: 51.8% vs.98.4%). This indicated that there is room for improvement in goal-directed care and person-centered care and implementing this measure can help to promote the goal setting and action plan development in goal-directed care.
- The American Geriatric Society's Guiding Principles for the Care of Older Adults with Multimorbidity and Person-Centered Care: A Definition and Essential Elements recommend an individual's preferences and goals should guide their care (American Geriatrics Society Expert Panel on Person-Centered Care, 2016; American Geriatrics Society Expert Panel on the Care of Older Adults with Multimorbidity, 2012)

III. Reliability/Validity

This measure has completed the measure testing. The measure was tested and intended to be used at the clinician group level. In addition, we provide individual clinician-level results by attributing participants to individual clinicians. We excluded the individual clinician with less than 30 participants in the individual clinician level results.

Reliability: signal-to-noise reliability

Clinician group-level results

Table a. provides the point estimate of mean signal-to-noise reliability, its standard error, and the 95% CI for the clinician group. The reliability estimate is 0.997, and the 95% CI is (0.992, 0.999), indicating very good reliability, which passes the scientific acceptability threshold 0.7 from Endorsement and Maintenance Guidebook from Battelle (Endorsement and Maintenance Guidebook (p4qm.org)

Table a

Number of groups	Number of eligible participants per group	Mean	SE	95% CI	
10	48-2495	0.997	0.003	0.992	0.999

Table b summarizes the distribution of clinician group-level signal-to-noise reliability estimates for the measure. The estimates range from 0.96 to 1.00. The minimum is 0.96, indicating very good reliability.

Table b. Distribution of signal-to-noise reliability							
Number of Groups	min	p10	p25	median	p75	p90	max
10	0.96	0.98	0.99	1.00	1.00	1.00	1.00

Individual clinician-level results

Table a. provides the point estimate of mean signal-to-noise reliability, its standard error, and the 95% CI for the clinician group. The reliability estimate is 0.997, and the 95% CI is (0.992, 0.999), indicating very good reliability, which passes the scientific acceptability threshold 0.7 from Endorsement and Maintenance Guidebook from Battelle (Endorsement and Maintenance Guidebook (p4qm.org)

Table a

Number of clinicians	Number of Eligible participants per clinicians	Mean	SE	95% CI	
101	30-371	0.98	0.00	0.97	0.98

Table b summarizes the distribution of clinician group-level signal-to-noise reliability estimates for the measure. The estimates range from 0.96 to 1.00. The minimum is 0.96, indicating very good reliability.

Table b. Distribution of signal-to-noise reliability							
Number of clinicians	min	p10	p25	median	p75	p90	max
101	0.61	0.96	0.98	1.00	1.00	1.00	1.00

Face validity

The results suggested high agreement among voters. We conducted the voting for two settings: primary care/LTSS and CCBHCs. For Primary care/LTSS settings, out of 12 voters, 10 agreed, 2 neither agreed nor disagreed. For CCBHC settings, out of 10 voters, 5 agreed, 5 neither agreed nor disagreed.

Exclusion frequency*Clinician group-level results*

Total number of excluded participants: 1,728

Individual clinician-level results

Total number of excluded participants: 1,692

Risk stratification

We recommend the measure stratify by clinician group type, e.g. primary care/LTSS site, CCBHCs, based on our testing results. Our testing results indicate that the demographic of the participants in CCBHCs is different from that in the primary care/LTSS site: the participants in CCBHCs are younger, and more uninsured compared to participants in primary care/LTSS sites. In addition, we observed that the performance in CCBHCs is higher with less variation compared to primary care/LTSS sites.

Data collection

Manual abstraction, other digital methods, or combination

For Patient Reported Outcome Performance Measures:

The measure uses two types of tools: goal attainment scaling (GAS) and patient-reported outcome measures (PROMs). GAS is a reliable method to set and evaluate person-centered goals. The measures use all the steps in the GAS process with a five-point scale to scoring. Regarding PROMSs, the measure uses all components within the included tools (below) and aligns with the tool as originally designed. All included tools (PROMIS-related tool, PHQ-9, GAD-7) do not require licenses or fees for use. All included tools are available for paper and electronic administration. PHQ-9 and GAD-7 have been translated into early 80 languages. PROMIS is available in Spanish and translated as requested with a fee. All the included tools are designed to assess various aspects of patient's health status with standardized and validated instruments.

IV. Endorsement

The new measure was never submitted for any endorsement.

V. Summary

This measure aligns with CMS meaningful measures 2.0 and fits into priorities: person-centered care, chronic conditions, and behavioral health. This measure aligns with MIPS's goal of promoting high-quality care and improving patient outcomes by incentivizing healthcare providers. The target population of this measure includes population from Medicare Fee for Service, Medicare Advantage, and Medicaid.