2023 Measures Under Consideration List

Program-Specific Measure Needs and Priorities

Contents

Overview

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The pre-rulemaking process is mandated by section 3014 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, enacted on March 23, 2010), which added Section 1890A to the Social Security Act (the Act), and which requires the Department of Health and Human Services (HHS) to establish a federal pre-rulemaking process for the selection of certain categories of quality and efficiency measures for use by HHS. These measures are described in section 1890(b)(7)(B) of the Act.

In preparation for the statutory requirement and to **remain transparent** and allow for additional **stakeholder feedback**, each spring CMS solicits public and private stakeholders to submit candidate quality and efficiency measures for consideration by the Agency as a part of the pre-rulemaking process.

The pre-rulemaking process requires that HHS make publicly available, not later than December 1 annually, a list of quality and efficiency measures HHS is considering adopting, through the federal rulemaking process, for use in the Medicare program. This list, referred to as the Measures under Consideration (MUC) List, is reviewed by a multi-stakeholder panel. The multi-stakeholder panel provides recommendations on behalf of the public to the Department of Health and Human Services (HHS) no later than February 1 annually. For additional information on the process and information from past years, please visit the Centers for Medicare & Medicaid Services (CMS) Pre-Rulemaking website. The following programs are included in the pre-rulemaking process.

Quality Programs

1. Ambulatory Surgical Center Quality Reporting Program (ASCQR)
2. End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
3. Home Health Quality Reporting Program (HH QRP)
4. Hospice Quality Reporting Program (HQRP)
5. Hospital-Acquired Condition Reduction Program (HACRP)
6. Hospital Inpatient Quality Reporting Program (HIQR)
7. Medicare Promoting Interoperability Program (PI)
8. Hospital Outpatient Quality Reporting Program (HOQR)
9. Hospital Readmissions Reduction Program (HRRP)
10. Hospital Value-Based Purchasing Program (HVBP)
11. Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
12. Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
13. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
14. Medicare Shared Savings Program (Shared Savings Program)
15. Merit-based Incentive Payment System (MIPS) Program
16. Medicare Part C and D Star Ratings
17. Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
18. Rural Emergency Hospital Quality Reporting Program (REHQR)
19. Skilled Nursing Facility Quality Reporting Program (SNF QRP)
20. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

Annually, CMS publishes the needs and priorities for each of the above identified programs. For each program in the pages that follow, CMS provides a brief summary of the:

- program history and structure
- current measure information (including the number of measures of each measure type)
- high priority areas for future measure consideration, and
- any program-specific measure requirements.

Through setting each program's needs and priorities, CMS hopes stakeholders will take this into account when developing measures and submitting them to CMS for consideration on the MUC List.

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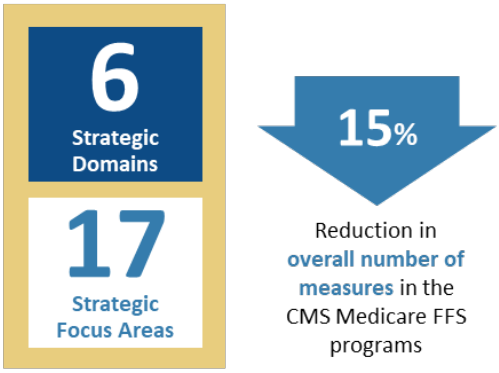
CMS Priorities

The CMS **National Quality Strategy** (NQS) identifies the activities of all agency components working together toward transformation of quality measurement and value-based programs, uniting strategic efforts to adopt measures that are the most critical to providing high quality care, reducing the burden of quality measure reporting, and driving better patient outcomes at lower costs.

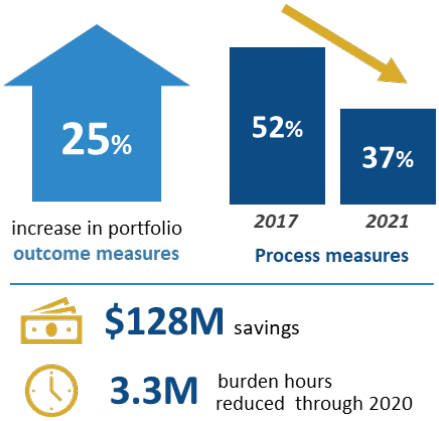
The QMAP delineates objectives supporting five interrelated goals:

Meaningful Measures 1.0 Accomplishments

- Since its inception in 2017, the Meaningful Measures Framework 1.0 has been utilized to review, reduce, and align measures
- Meaningful Measures 1.0 highlighted 6 strategic domains and 17 strategic focus areas
- This has resulted in a 15% reduction of the overall number of measures in the CMS Medicare Fee-For-Service (Medicare FFS) programs (from 534 to 460 measures)



- Overall, the measures portfolio has demonstrated a 25% increase in percentage of outcome measures; the percentage of process measures has dropped from 52% in 2017 to 37% in 2021
- Streamlining measures has a projected savings of an estimated $128M and a reduction of 3.3M burden hours through 2020*



*Seema Verma's Speech at the 2020 CMS Quality Conference: https://www.cms.gov/newsroom/press-releases/speech-remarks-cms-administrator-seema-verma-2020-cms-quality-conference

Meaningful Measures 2.0

- Although the original Meaningful Measures initiative accomplished its initial goals, its scope and purpose have evolved to keep pace with a rapidly changing healthcare environment

With Meaningful Measures 2.0:

- CMS will not only continue to reduce the number of measures in its programs but will further shape the entire ecosystem of quality measures that drive value-based care
- CMS will promote innovation and modernization of all aspects of quality, addressing a wide variety of settings, stakeholders, and measurement requirements
- CMS plans to better address health care priorities and gaps, emphasize digital quality measurement, and promote patient perspectives

Fig. 1: Priorities and Measure Gaps of Meaningful Measures 2.0

Priorities & Measure Gaps
Using only high-value quality measures that impact key quality domains
Aligning measures across value-based programs and across partners, including CMS, federal, and private entities
Prioritizing outcome and patient-reported measures
Transforming measures to be fully digital and incorporating all-payer data
Developing and implementing measures that reflect social and economic determinants

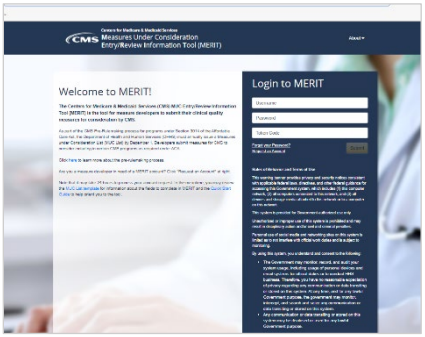
Future Directions of Quality Measures

Looking to the future, CMS will continue to leverage the National Quality Strategy (NQS) and Meaningful Measures 2.0 to further evolve its portfolio to include more outcome measures (including population outcomes), patient-reported outcome performance measures (PRO-PMs), and more digital measures. While expanding the number of outcome measures remains an important priority and a goal of Meaningful Measures 2.0, process measures continue to be important metrics of quality. However, CMS is placing greater emphasis on the need to demonstrate the link between process measures, quality actions, and important outcomes. Process measures that drive improvement in health outcomes are more impactful than those that are "check box" in nature (i.e., those that treat measurement as an end, rather than drive healthcare quality improvement). Emphasizing health outcomes will also facilitate the transition to more composite measures in which adherence to all components is a marker of healthcare quality.

Finally, CMS will prioritize the key measure focus areas of equity, behavioral health, and maternal health, as well as measures that support appropriate utilization and culturally and linguistically appropriate services (CLAS).

Measure Selection Requirements for CMS Quality Programs

CMS quality initiative programs have identified requirements for selecting measures for future reporting years. In order for measures to be considered, **all of the following requirements identified in Section 1 and 2 below must be met**, in addition to program-specific requirements identified in each program description. Note that CMS is not required to adopt measures that are published on the MUC List. Quality and efficiency measure submissions are preferred to be:



- Fully developed and tested for the appropriate provider level (e.g., tested for clinicians' measurement if being submitted for consideration for the Merit-based Incentive Payment System Program), and adequate documentation to support testing results must be submitted. If insufficient information is submitted, CMS will be unable to further consider the measure for inclusion on a MUC List; and
- Submitted for CMS review using CMS MERIT, the web-based submission tool.

1. Measure Information Requirements

a. Title
b. Numerator
c. Denominator
d. Exclusions
e. Measure steward
f. Link to full specifications
g. Information about testing
h. Information about evidence to support the measure
i. Estimated impact and cost
j. Established mechanism for data collection (e.g., CDC NHSN, AHRQ HCAHPS); and
k. Peer Reviewed Journal Article Requirement (Merit-based Incentive Payment System Program only)

In addition to the aforementioned requirements, electronically specified clinical quality measures (eCQMs) require the following information:

l. Measure Authoring Tool (MAT) number
m. Bonnie test cases with 100% logic coverage
n. Attestation that value sets are published in the Value Set Authority Center (VSAC)
o. Feasibility scorecard
p. Attestation that the measure has a Health Quality Measures Format (HQMF) specification

2. Measure Selection Requirements

Selected measures must:

a. Support the CMS and national healthcare priorities, prioritizing outcome measures, patient reported outcome measures, and digital measures
b. Respond to specific program goals and statutory requirements
c. Address important condition topic with a performance gap and strong scientific evidence base to demonstrate measure can lead to desired outcomes and/or more affordable care
d. Have written consent for any proprietary algorithms needed for measure production
e. Promote alignment with CMS program attributes and across HHS and private payer programs
f. Identify opportunities for improvement (e.g., not be "topped out")
g. Not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)
h. Not duplicate other measures currently implemented in programs

3. Candidate Measure Submission Guidance

- Measures must contain adequate specifications
- Measures on a published MUC List but not selected by programs can be considered for selection in future rulemaking cycles
    - Measures do not need to be resubmitted unless
        - There are substantive changes to specifications
        - A measure steward would like the measure to be considered for a different program
- Measures may be part of mandatory reporting programs or optional reporting programs
- MUC List measures must fulfill a measurement need and are assessed for alignment among CMS programs when applicable

CMS is not required to adopt measures that are published on the MUC List

Program-Specific Measure Needs and Priorities

The following sections provide background, current information on healthcare quality and efficiency measures, and future measure needs for each program covered by CMS Pre-Rulemaking.

Ambulatory Surgical Center Quality Reporting Program

Program History and Structure:

- The Ambulatory Surgical Center Quality Reporting Program (ASCQR) was established under the authority provided by Section 109(b) of the Medicare Improvements and Extension Act of 2006, Division B, Title I of the Tax Relief and Health Care Act (TRHCA) of 2006
- The statute provides the authority for requiring Ambulatory Surgical Centers (ASCs) paid under the ASC fee schedule (ASCFS) to report data on services provided in this care setting
- ASCs may receive a two-percentage point (2%) payment reduction to their ASCFS annual payment update for not meeting program requirements. CMS implemented this program so that payment determinations were effective beginning with the Calendar Year (CY) 2014 payment update

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	10
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	2
Structure	0
Total	**13**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	2*
Equity	0
Safety	5
Affordability and Efficiency	4
Chronic Conditions	0
Wellness and Prevention	2
Seamless Care Coordination	0
Behavioral Health	0
Total	**13**

High Priority Areas for Future Measure Consideration:

- The key strategy for the ASCQR Program is to measure and publicly report quality of care measures for this outpatient setting. Optimally, quality measures of different types, consistent with statutory authority, would align to the extent feasible and appropriate, so that Medicare beneficiaries and other consumers can compare quality metrics across different facility types
- **Safety**
- **Patient Experience**
- **Person and Family Engagement**
- **Best Practices of Healthy Living**
- **Effective Prevention and Treatment**
- **Making Care Affordable**
- **Communication/Care Coordination**

Measure Requirements:

CMS applies the below criteria and considerations for measures that may be considered for potential adoption in the Ambulatory Surgical Center Quality Reporting Program:

1. Measures must adhere to CMS statutory requirements

* ASC 11 is in voluntary reporting until 2025 reporting/CY 2027 payment determination.

a. Measures are required to reflect consensus among affected parties, and to the extent feasible, be endorsed by the national consensus entity with a contract under Section 1890(a) of the Social Security Act

b. The Secretary may select a measure in an area or topic in which a feasible and practical measure has not been endorsed, by the entity with a contract under Section 1890(a) of the Social Security Act, if endorsed measures have been given due consideration

c. Measures shall address quality of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in the ambulatory care setting

2. Measures are selected to address a National Quality Strategy (NQS) priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration
3. Measures are selected to address an important condition/topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization
4. Measures optimally would be field tested for the ASC clinical setting
5. Measure is clinically relevant
6. Data collection and submission burden of selected measures should be limited to the fullest extent possible since many ASCs are small facilities with limited staffing
7. Measures optimally would supply sufficient case numbers for differentiation of ASC performance
8. Measures are selected to promote alignment across HHS and CMS programs

End-Stage Renal Disease Quality Incentive Program

Program History and Structure:

- The End-Stage Renal Disease quality incentive program (ESRD QIP) is the most recent step in fostering improved patient outcomes by establishing incentives for dialysis facilities to meet or exceed performance standards established by CMS
- The ESRD QIP is authorized by section 1881(h) of the Social Security Act, which was added by section 153(c) of Medicare Improvements for Patients and Providers (MIPPA) Act (the Act)

- CMS established the ESRD QIP for Payment Year (PY) 2012, the initial year of the program in which payment reductions were applied, in two rules published in the Federal Register on August 12, 2010, and January 5, 2011 (75 FR 49030 and 76 FR 628, respectively)
- Subsequently, CMS published rules in the Federal Register detailing the ESRD QIP requirements for PY 2013 through FY 2016
- Most recently, CMS published a rule on November 6, 2014, in the Federal Register (79 FR 66119), providing the ESRD QIP requirements for PY2017 and PY 2018, with the intention of providing an additional year between finalization of the rule and implementation in future rules
- Section 1881(h) of the Act requires the Secretary to establish an ESRD QIP by:
  - Selecting measures
  - Establishing the performance standards that apply to the individual measures
  - Specifying a performance period with respect to a year
  - Developing a methodology for assessing the total performance of each facility based on the performance standards with respect to the measures for a performance period
  - Applying an appropriate payment reduction to facilities that do not meet or exceed the established Total Performance Score (TPS)

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	2
Outcome	2
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	3
Structure	1
Total	**8**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	0
Equity	0
Safety	3
Affordability and Efficiency	0
Chronic Conditions	3
Wellness and Prevention	0
Seamless Care Coordination	1
Behavioral Health	1
Total	**8**

High Priority Areas for Future Measure Consideration:

- **Outcomes:** The ESRD QIP will prioritize outcome measures over process measures
- **Home Dialysis**: Research has suggested that dialyzing at home is often preferred by patients and physicians and results in improved quality of life and overall lower medical expenditures. Although some measures in the ESRD QIP apply to home dialysis facilities, the majority of measures do not apply to facilities that have high rates of home dialysis
- **Transplantation**: Transplantation is widely viewed as the optimal treatment for most patients with ESRD, generally increasing survival and quality of life while reducing medical expenditures. While the ESRD QIP currently contains a measure that assesses the percentage of prevalent patients waitlisted, CMS recognizes the importance of measuring the extent to which patients actually receive transplants
- **Health Equity**: Research suggest that there are several racial and socioeconomic disparities in dialysis outcomes, access to high quality care and alternative renal replacement modalities. CMS is committed to achieving equity in healthcare outcomes for patients with ESRD by promoting efforts to expand the collection of social risk factor data, providing actionable and useful results to dialysis providers and promoting dialysis provider accountability for healthcare disparities
- **Patient-and-Caregiver-Centered Experience of Care**: Sustaining and recovering patient quality of life was among the original goals of the Medicare ESRD QIP. This includes such issues as physical function, independence, and cognition. Quality of Life measures should also consider the life goals of the patient where feasible, to the point of including Patient-Reported Outcomes

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the End-Stage Renal Disease Quality Incentive Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measures for anemia management reflecting FDA labeling, as well as measures for dialysis adequacy
2. Measure(s) of patient satisfaction, to the extent feasible
3. Measures of iron management, bone mineral metabolism, and vascular access, to the extent feasible
4. Measures specific to conditions treated with oral-only drugs and, to the extent feasible, that such measures be outcomes measures
5. Measures should be NQF endorsed, save where due consideration is given to endorsed measures of the same specified area or medical topic
6. Must consider the availability of measures that address the unique treatment needs of children and young adults with kidney failure
7. May incorporate Medicare claims and/or EQRS data, alternative data sources will be considered dependent upon available infrastructure

Requirements 1-4 above are mandated by statute

Home Health Quality Reporting Program

Program History and Structure:

- The Home Health Quality Reporting Program (HH QRP) was established in accordance with section 1895 (b)(3)(B)(v)(II) of the Social Security Act
- Home Health Agencies (HHAs) are required by the Act to submit quality data for use in evaluating quality for Home Health agencies
- HHAs that do not submit quality data to the Secretary are subject to a 2 percent reduction in the annual payment update (Section 1895(b) (3)(B)(v)(I))

Expanding the Home Health Value-based Purchasing Model:

- The original Home Health Value-Based Purchasing (HHVBP) Model was established by Section 1115A of the Affordable Care Act and finalized in the Calendar Year (CY) 2016 Home Health Prospective Payment System (HH PPS) final rule (80 FR 68624), and implemented in nine states by the Center for Medicare and Medicaid Innovation (Innovation Center)

- In CY 2022 HH PPS Final rule finalized the expansion of the HHVBP model to include Medicare-certified HHAs in all fifty (50) states, District of Columbia, and the U.S. territories
- The expanded HHVBP model currently includes 12 measures including 2 claims based, 5 OASIS based and 5 Patient Satisfaction Measures (CAHPS)
- HHA will have their payment adjusted +/- 5% based on the level of quality the HHA provides in the performance period
- When the expanded HHVBP Model adds measures in the future, they may be measures that have been in use in the HH QRP
- CY 2022 is a pre-implementation year. CY 2023 will be the first year in which performance will be tied to payment in CY 2025
- Performance reports will be in IQIES
- Public reporting of performance in the Model will be on the Model's website

Current Measure Information:

- There are 20 measures currently adopted for the HH QRP. These are derived from the Outcome and Assessment Information Set (OASIS), Medicare Fee-For-Service claims, and the Home Health (HH) Care Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS)

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	12
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	6
Structure	0
Total	**20**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	8
Equity	0
Safety	3
Affordability and Efficiency	6
Chronic Conditions	0
Wellness and Prevention	1
Seamless Care Coordination	2
Behavioral Health	0
Total	**20**

High Priority Areas for Future Measure Consideration:

HH QRP identified the following as high priorities for future measure consideration:

- **Health Equity**: Measures that would address health equity

Measure Requirements:

For the Home Health Quality Reporting Program (HH QRP), The IMPACT Act requires the development and reporting of quality measure addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below

1. Quality Measure Domains:
    a. Skin integrity and changes in skin integrity
    b. Functional status, cognitive function, and changes in function and cognitive function
    c. Medication reconciliation
    d. Incidence of major falls
    e. Transfer of health information and care preferences when an individual transitions
2. Resource Use and Other Measure Domains:
    a. Resource use measures, including total estimated Medicare spending per beneficiary
    b. Discharge to community
    c. All-condition risk-adjusted potentially preventable hospital readmissions rates

3. Measures implemented in the HH QRP are statutorily required to reflect consensus among stakeholders affected
4. Measures adopted in the HH QRP may be available for public reporting on *Care Compare*
5. Preference will be given to measures that are endorsed by a CMS ConsensusBased Entity (CBE)
6. Measure performance should demonstrate variation amongst home health agencies and opportunities for improvement, exception for function maintenance measure
7. Measures are preferred to be fully developed, with completed testing results at the national level and ready for implementation at the time of submission (CMS' internal evaluation)
8. No new measures adopted into the HH QRP will duplicate other measures currently/previously implemented into the program

Hospice Quality Reporting Program

Program History and Structure:

- The Hospice Quality Reporting Program (HQRP) was established in accordance with Section 1814(i)(5) of the Social Security Act, as amended by section 3004(c) of the Affordable Care Act and further amended by CAA of 2021
- The HQRP applies to all patients in Medicare-certified hospices, regardless of payer source
- HQRP measure development and selection activities are considered established national priorities and requires input from multi-stakeholder groups
- Beginning in FY 2014, Hospices that fail to submit quality data are subject to a two-percentage point (2%) reduction to their annual payment update that changes to a four-percentage point (4%) reduction beginning in FY 2024

Current Measure Information:

Measure Type	Number of Measures
Composite	2
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	0
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	1
Structure	0
Total	**4**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	4
Equity	0
Safety	0
Affordability and Efficiency	0
Chronic Conditions	0
Wellness and Prevention	0
Seamless Care Coordination	0
Behavioral Health	0
Total	**4**

High Priority Areas for Future Measure Consideration:

HQRP identified the following as high priorities for future measure consideration:

- The Hospice Outcome & Patient Evaluations (HOPE) tool Measure Concepts
  - **Process Measures**
- **Hybrid Measures**: Develop hybrid measures which would combine data from different sources, such as claims, assessments, or other data sources
- **Health Equity**: Measures that address health equity and focus on underserved populations' access to care

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospice Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measures implemented in the HQRP are statutorily required to reflect consensus among stakeholders affected
2. Measures adopted in the HQRP are available for public reporting on *Care Compare*
3. Measures are preferred to be fully developed, with completed testing results at the national level and ready for implementation at the time of submission
4. Preference will be given to measures that are endorsed by the CMS Consensus-Based Entity (CBE)
5. Measure performance should demonstrate variation amongst Hospices and opportunities for improvement
6. Measures adopted into HQRP fill a gap or high priority area as determined by OIG, MedPAC, or other stakeholders

Hospital Acquired Condition Reduction Program

Program History and Structure:

- Created under Section 1886(p) of the Social Security Act (the Act), the HACRP provides an incentive for hospitals to reduce the number of HACs
- Effective Fiscal Year (FY) 2015 and beyond, the HACRP requires the Secretary to make payment adjustments to applicable hospitals that rank in the worst-performing quartile of all subsection (d) hospitals relative to a national average of HACs acquired during an applicable hospital stay
- HACs include a condition identified in subsection 1886(d)(4)(D)(iv) of the Act and any other condition determined appropriate by the Secretary
- Section 1886(p)(6)(C) of the Act requires the HAC information be posted on the *Care Compare* website
- CMS finalized in the FY 2019 IPPS/LTCH PPS final rule a scoring methodology change that removed domains and assigns equal weighting to each measure for which a hospital has a measure beginning with the FY 2020 HACRP
- The program uses the CMS Patient Safety Indicator 90 (CMS PSI 90) and five Healthcare-Associated Infections (HAI) as collected by the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)
- The Total HAC Score is the sum of the equally weighted average of the hospital's measure scores

Current Measure Information:

Measure Type	Number of Measures
Composite	1
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	5
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	0
Total	**6**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	0
Equity	0
Safety	6
Affordability and Efficiency	0
Chronic Conditions	0
Wellness and Prevention	0
Seamless Care Coordination	0
Behavioral Health	0
Total	**6**

High Priority Areas for Future Measure Consideration:

Making Care Safer

- Measures that meet the Measure Requirements below that are electronic Clinical Quality Measures (eCQMs)
- Measures that address adverse drug events during the inpatient stay
- Additional surgical site infection locations that are not already covered within an existing measure in the program
- Outcome risk-adjusted measures that capture outcomes from hospital-acquired conditions and are risk-adjusted to account for patient and/or facility differences (e.g., multiple comorbidities, patient care location)

- Measures that address diagnostic errors such as harm from receiving improper tests or treatment, harm from not receiving proper tests or treatment, harm from failure to diagnose, or harm from improper diagnosis
- Measures that address causes of hospital harm such as an all-cause harm measure or a measure that encompasses multiple harms
- Measures that demonstrate safety and/or high reliability practices and outcomes

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Acquired Condition Reduction Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measures must be identified as a HAC under Section 1886(d)(4)(D) or be a condition identified by the Secretary
2. Measures must address high cost or high-volume conditions
3. Measures must be easily preventable by using evidence-based guidelines
4. Measures must not require additional system infrastructure for data submission and collection
5. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital Inpatient Quality Reporting Program

Program History and Structure:

- Established by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and expanded by the Deficit Reduction Act of 2005
- Hospitals paid under the Inpatient Prospective Payment System (IPPS) are required to report on measures in the program
- Failure to meet the requirements of the Hospital IQR Program will result in a reduction by 1/4 to a hospital's fiscal year IPPS annual payment update
- Hospitals that choose to not participate in the program receive a reduction by that same amount
- Hospitals not included in the Hospital IQR Program, such as critical access hospitals and hospitals located in Puerto Rico and the U.S. Territories, are permitted to participate in voluntary quality reporting

- Performance of quality measures are publicly reported on the CMS *Care Compare* website

Current Measure Information:

Measure Type	Number of Measures
Composite	2
Cost/Resource Use	5
Intermediate Outcome	0
Outcome	13
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	13
Structure	2
Total	**36**

Meaningful Measures 2.0 Healthcare Priorities	Number of Measures
Person-centered Care	2
Equity	3
Safety	10
Affordability and Efficiency	11
Chronic Conditions	6
Wellness and Prevention	3
Seamless Care Coordination	0
Behavioral Health	1
Total	**36**

High Priority Areas for Future Measure Consideration:

- **PRO-PM**
- **Care Coordination**
- **Health Equity**
- **Maternal Health**
- **Safety**
- **Outcome eCQMs**
- **Behavioral Health**
- **Cancer**
- **Geriatric/Age Friendly**

All Hospital Inpatient Quality Reporting Program eCQMs are reportable in the Medicare Promoting Interoperability Program. Participants in the Promoting Interoperability Program are also required to report on four scored objectives and their measures (i.e., Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, Public Health, and Clinical Data Exchange) and required to report (yes/no) on the Protect Patient Health Information objective.

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Inpatient Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements. For more detail on statutory requirements, please refer to the CMS website
2. If feasible, measure must be claims-based or an electronically specified clinical quality measure (eCQM)
3. A Measure Authoring Tool (MAT) number must be provided for all eCQMs, created in the Health Quality Measures Format (HQMF) format
4. eCQMs must undergo reliability and validity testing and must have successfully passed feasibility testing
5. Measure is preferred to be fully developed, tested, and validated in the acute inpatient setting
6. Measure may not require reporting to a proprietary registry
7. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization
8. Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration
9. Measure must promote alignment across HHS and CMS programs

10. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital Outpatient Quality Reporting Program

Program History and Structure:

- Established by Section 109 of the Tax Relief and Health Care Act (TRHCA) of 2006
- The program requires subsection (d) hospitals providing outpatient services paid under the Outpatient Prospective Payment System (OPPS) to report on process, structure, outcomes, efficiency, costs of care, and patient experience of care
- Pay-for-Reporting Program
- Facilities may receive a two-percentage point (2%) reduction from their annual payment update (APU) under the OPPS for not meeting program requirements
- Data publicly reported on the CMS *Hospital Compare* website

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	3
Patient Reported Outcome-Based Performance Measure (PRO-PM)	2
Process	9
Structure	1
Total	**15**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	4
Equity	0
Safety	1
Affordability and Efficiency	7
Chronic Conditions	1
Wellness and Prevention	2
Seamless Care Coordination	0
Behavioral Health	0
Total	**15**

High Priority Areas for Future Measure Consideration:

The key strategy for the Hospital Outpatient Quality Reporting (OQR) Program is to measure and publicly report quality of care measures for the hospital outpatient and emergency departments. Specifically, quality measures of different types, consistent with statutory authority, would align to the extent feasible and appropriate, so that Medicare beneficiaries and other consumers can compare quality metrics across different facility types. More importantly, ensure equivalent high quality and equitable care across the board as care/procedures move toward outpatient settings

- **Safety**
- **Equity**
- **Person-Centered Care**
- **Behavioral Health**
- **PRO-PM**
- **Outcome eCQMs**

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Outpatient Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements
    a. The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care, including quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that

relate to services furnished in outpatient settings in hospitals and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities; as well as, make these data publicly available on the Internet website of the Centers for Medicare and Medicaid Services under section 1833 (t)(17)(C) of the Act

b. Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii) of the Act

2. Measure is selected to address:

   a. a NQS priority/CMS strategy goal, with preference for measures addressing the high priority domains for future measure consideration

   b. an important condition/topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization

   c. promote alignment across HHS and CMS programs

3. Measure is preferred to be fully developed, tested, and validated in the hospital outpatient setting

4. Feasibility of Implementation: An evaluation of feasibility is based on factors including, but not limited to

   a. The level of burden associated with collecting, reporting, and validating measure data, both for CMS and for the end user.

   b. Feasibility and readiness of CMS system for data collection.

Hospital Readmissions Reduction Program

Program History and Structure:

- The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program established under Section 1886(q) of the Social Security Act
- Under HRRP, CMS reduces payments to subsection (d) hospitals with excess readmissions
- The 21st Century Cures Act directs CMS to use a stratified methodology (beginning in FY 2019) to evaluate a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full Medicaid benefits
- The following steps are taken to calculate payment reductions under HRRP:

1. For each of the six conditions/procedures, CMS calculates an excess readmission ratio (ERR)
2. CMS stratifies hospitals into peer groups based on the dual proportion, and calculates median ERRs for each peer group
3. CMS compares each hospital's performance relative to the peer group median ERR for each measure
4. CMS calculates the hospital-specific payment reduction. The maximum payment reduction is 3 percent

Current Measure Information:

- HRRP currently includes six condition/procedure-specific claims-based readmission measures

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	6
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	0
Total	**6**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	0
Equity	0
Safety	0
Affordability and Efficiency	6
Chronic Conditions	0
Wellness and Prevention	0
Seamless Care Coordination	0
Behavioral Health	0
Total	**6**

High Priority Areas for Future Measure Consideration:

- Improving scope by covering more clinical conditions, procedures, or topics
- Considering Agency priorities (e.g., behavioral or mental health, including substance use disorders) and possible application strategies on health equity

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Readmissions Reduction Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR Program and posting dates on the *Care Compare* website
2. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists for under-served and under-resourced populations groups, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization
3. Measure is preferred to be fully developed, tested, and validated in the acute inpatient setting
4. Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration
5. Measure must promote alignment across HHS and CMS programs
6. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Hospital Value-Based Purchasing Program

Program History and Structure:

- The Hospital Value-Based Purchasing (HVBP) Program was established by Section 3001(a) of the Affordable Care Act, under which value-based incentive payments are made each fiscal year to hospitals meeting performance standards established for a performance period for such fiscal year
- Measures are eligible for adoption in the Hospital VBP Program based on the statutory requirements, including specification under the Hospital Inpatient Quality Reporting (IQR) Program, and posting dates on the *Care Compare* website

- The Secretary shall select measures, other than measures of readmissions, for purposes of the Program. In addition, a cost efficiency measure, currently the Medicare Spending Per Beneficiary measure, must be included

Current Measure Information:

- The Hospital VBP Program currently includes 13 measures across four domains. The domains include Safety, Patient and Community Engagement, Clinical and Cost and Efficiency

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	12
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	0
Total	**13**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	1
Equity	0
Safety	7
Affordability and Efficiency	1
Chronic Conditions	4
Wellness and Prevention	0
Seamless Care Coordination	0
Behavioral Health	0
Total	**13**

High Priority Areas for Future Measure Consideration:

- **PRO-PM**
- **Outcome eCQMs**
- **Care Coordination**
- **Health Equity**

- **Maternal Health**
- **Behavioral Health**

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Hospital Value-Based Purchasing Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must adhere to CMS statutory requirements, including specification under the Hospital IQR Program and posting dates on the *Care Compare* website
2. Measure may not require reporting to a proprietary registry
3. Measure must address an important condition/topic for which there is analytic evidence that a performance gap exists, and that measure implementation can lead to improvement in desired outcomes, costs, or resource utilization
4. Measure is preferred to be fully developed, tested, and validated in the acute inpatient setting
5. Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration
6. Measure must promote alignment across HHS and CMS programs
7. Measure steward will provide CMS with technical assistance and clarifications on the measure as needed

Inpatient Psychiatric Facility Quality Reporting Program

Program History and Structure:

- Sections 3401(f) and 10322(a) of the Affordable Care Act amended section 1886(s)(4) of the Social Security Act to require the Secretary to implement a quality reporting program for inpatient psychiatric hospitals and psychiatric units
- Applies to all psychiatric hospitals and psychiatric units paid under Medicare's Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)
- IPFQR is a "pay-for-reporting" program.
    - Non-compliance results in a two-percentage point (2%) reduction to the market basket update

        - e.g., an IPF eligible for a 4% update increase would receive a 2% increase if it failed to comply with reporting requirements
    - Update reductions are noncumulative across payment years
- Designed to provide patients, and their families and caregivers, with quality-of-care information to help make informed decisions about their health care options
- Intended to improve the quality of inpatient psychiatric care provided to beneficiaries by ensuring that providers are aware of and reporting on practices related to quality care
- FY 2014 was the first payment determination
- Payment reductions for non-participation or failure to submit quality measures are effective as of October 1 of each applicable fiscal year, i.e., for FY 2015, the payment reduction is effective for services provided starting on October 1, 2014

Current Measure Information:

Measure Type	Number of Measures
Composite	3
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	1
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	11
Structure	0
Total	**15**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	0
Equity	0
Safety	2
Affordability and Efficiency	1
Chronic Conditions	0
Wellness and Prevention	3
Seamless Care Coordination	2
Behavioral Health	7
Total	**15**

High Priority Areas for Future Measure Consideration:

- **Patient Experience of Care in an Inpatient Psychiatric Facility**
- **PRO-PM**
- **All-cause post-discharge mortality**
- **Depression focused patient-reported outcome performance measure (PRO-PM)**
- **Suicide Risk Assessment or Suicide Ideation**

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Inpatient Psychiatric Facility Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure must promote alignment across HHS and CMS programs
2. Measure must adhere to CMS statutory requirements, including specification under the IPFQR Program
3. Measure must address a Meaningful Measure area, with preference for measures addressing the high priority domains and/or measurement gaps for future measure consideration
4. Measure results and performance should identify opportunities for improvement

Inpatient Rehabilitation Facility Quality Reporting Program

Program History and Structure:

- The Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) was implemented with the fiscal year (FY) 2012 IRF PPS Final Rule. Quality reporting requirements were mandated in section 3004(b) of the Patient Protection and Affordable Care Act (ACA) of 2010 which amended section 1886(j)(7) of the Social Security Act (SSA)
- The IRF QRP is a pay for reporting program where successfully meeting the requirements for each FY means IRFs must submit data on quality measures. IRFs must also submit standardized patient assessment data with regard to quality measures and standardized patient assessment data elements
- Failure to meet the IRF QRP requirements results in a two-percentage point (2%) reduction in IRFs Annual Increase Factor (AIF) for the corresponding, future FY payments
- Measures adopted in the IRF QRP are publicly reported on the *Care Compare* website

Current Measure Information:

- There are 18 measures currently adopted for the IRF QRP. These are derived from the IRF-Patient Assessment Instrument (IRF PAI), the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) and Medicare Fee-For-Service claims

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	11
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	6
Structure	0
Total	**18**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	5
Equity	0
Safety	5
Affordability and Efficiency	4
Chronic Conditions	0
Wellness and Prevention	2
Seamless Care Coordination	2
Behavioral Health	0
Total	**18**

High Priority Areas for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Inpatient Psychiatric Facility Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. For the Inpatient Rehabilitation Facility Quality Reporting Program, The IMPACT Act requires the development and reporting of quality measure addressing 5 domains in

addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below:

a. Quality Measure Domains:

    i. Skin integrity and changes in skin integrity

    ii. Functional status, cognitive function, and changes in function and cognitive function

    iii. Medication reconciliation

    iv. Incidence of major falls

    v. Transfer of health information and care preferences when an individual transitions

b. Resource Use and Other Measure Domains:

    i. Resource use measures, including total estimated Medicare spending per beneficiary

    ii. Discharge to community

    iii. All-condition risk-adjusted potentially preventable hospital readmissions rates

2. Quality measures selected for the IRF QRP must be endorsed by the NQF unless they meet the statutory criteria for exception
3. Measures address an important condition/topic with a performance gap and have a strong scientific evidence base to demonstrate that the measure can lead to the desired outcomes and/or more affordable care
4. Reporting of measures is feasible to implement, and measures have preferably been fully developed and tested
5. Results for and performance of measures should identify opportunities for improvement
6. Potential use of a measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)
7. Measures adopted in the IRF QRP are publicly reported on *Care Compare*

Long-Term Care Hospital Quality Reporting Program

Program History and Structure:

- The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) was established in the Fiscal Year (FY) 2012 Inpatient Prospective Payment System (PPS)/LTCH PPS Final Rule, as authorized by Section 3004(a) of the Patient Protection and Affordable Care Act of 2010
- The LTCH QRP is a pay for reporting program where successfully meeting the requirements for each fiscal year means LTCHs must meet or exceed two separate data completeness thresholds:
  - One threshold set at 80% for completion of quality measure data collected using the LTCH Continuity Assessment and Record of Evaluation (CARE) Data Set (LCDS).
  - The second set at 100% for quality measure data collected and submitted using the Centers for Disease Control (CDC) National Healthcare Surveillance Network (NHSN)
- Any LTCH who does not meet reporting requirements may be subject to a two-percentage point (2%) reduction in their Annual Payment Update

Current Measure Information:

- There are 18 measures currently adopted for the LTCH QRP, the majority of which are required by statute
- These are derived from the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS), the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) and Medicare Fee-For-Service claims

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	9
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	8
Structure	0
Total	**18**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	4
Equity	0
Safety	7
Affordability and Efficiency	3
Chronic Conditions	0
Wellness and Prevention	2
Seamless Care Coordination	2
Behavioral Health	0
Total	**18**

High Priority Areas for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity
- **Long-term Care**: Measures that reflect care specific to LTCHs, such as long-term ventilator care

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Long-Term Care Hospital Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. The IMPACT Act requires CMS to develop and implement quality measures to satisfy at least five measure domains:
    a. functional status, cognitive function, and changes in function and cognitive function
    b. skin integrity and changes in skin integrity
    c. medication reconciliation
    d. incidence of major falls
    e. the transfer of health information when the individual transitions from the hospital/critical access hospital to PAC provider or home, or from PAC provider to another setting
2. The IMPACT Act also requires the implementation of resource use and other measures in satisfaction of at least these following domains:
    a. total estimated Medicare spending per beneficiary
    b. discharge to the community

c. all condition risk adjusted potentially preventable hospital readmission rates

3. The LTCH QRP measure development and selection activities consider established national priorities and input from multi-stakeholder groups
4. Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more affordable care
5. Measure reporting is feasible to implement, and measures have preferably been fully developed and tested
6. Measure results and performance should identify opportunities for improvement
7. Potential use of the measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)

Medicare Shared Savings Program

Program History and Structure:

- The Medicare Shared Savings Program (Shared Savings Program) is Medicare's national value-based payment program for Accountable Care Organizations (ACO). ACO's facilitate coordination and cooperation among health care providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce the rate of growth in health care costs
- Eligible clinicians, hospitals, and other health care providers can voluntarily join or form an ACO
- ACOs share in savings by meeting the quality performance standard for the performance year and lowering the growth in Medicare spending
- ACOs participating under a two-sided shared savings/losses model may owe losses if they increase costs and the amount owed is based on quality performance depending on track
- For performance years 2023 and 2024, ACOs will be required to report quality data via the Alternative Payment Model (APM) Performance Pathway (APP).
    - ACOs can choose to report either the 10 measures under the CMS Web Interface or the 3 eCQMs/Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQMs)

- ACOs must field the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) for MIPS survey
- CMS will calculate 2 claims-based outcome measures using administrative claims data: the Hospital Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups measure and the Clinician and Clinician Group Risk-Standardized Hospital Admissions Rates for Patients with Multiple Chronic Conditions measure

- For performance year 2025 and subsequent performance years, ACOs will be required to report:
  - the 3 eCQMs/MIPS CQMs, field the CAHPS for MIPS survey, and CMS will continue to calculate the 2 claims-based outcome measures noted above

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	2
Outcome	3
Patient Reported Outcome-Based Performance Measure (PRO-PM)	1
Process	7
Structure	0
Total	**13**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	1
Equity	0
Safety	1
Affordability and Efficiency	1
Chronic Conditions	4
Wellness and Prevention	4
Seamless Care Coordination	0
Behavioral Health	2
Total	**13**

High Priority Areas for Future Measure Consideration:

- **Shared Savings Measures**: The Shared Savings Program goals include identification measures of success in the delivery of high-quality health care at the individual and population levels and align with HHS and CMS priorities, with a focus on outcomes
- **Health Equity**: Measures that promote health equity and address social determinants of health

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Shared Savings Program. At a minimum, the following requirements must be met for consideration in the program:

1. Outcome measures that address conditions that are high-cost and affect a high volume of Medicare patients
2. Measures that are targeted to the needs and gaps in care of Medicare Fee-For-Service patients and their caregivers
3. Measures that align with CMS quality reporting and value-based initiatives, including Quality Payment Program
4. Measures that support improved population health
5. Measures addressing high-priority healthcare issues, such as health equity and opioid use
6. Measures that align with recommendations from the Core Quality Measures Collaborative

Merit-based Incentive Payment System Program

Program History and Structure:

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. MACRA requires CMS, by law, to implement an incentive program for clinicians. This program, referred to as the Quality Payment Program, provides two participation pathways for clinicians:
    - The Merit-based Incentive Payment System (MIPS): Traditional MIPS or MIPS Value Pathways (MVPs)
    - Advanced Alternative Payment Models (Advanced APMs)

- MIPS combines three Medicare "legacy" programs – the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals – into a single program. Under MIPS, there are four connected performance categories that will affect a clinician's future Medicare payments
- Starting with the 2023 performance period, MIPS eligible clinicians and groups may choose to report traditional MIPS or MIPS MVPs. MVPs include a subset of measures and activities that are related to a given specialty or medical condition. MVPs offer reduced reporting requirements, allowing MVP participants to report on a smaller, more cohesive subset of measures and activities (within the measures and activities available under traditional MIPS)
- Each performance category is scored independently and has a specific weight, indicating its contribution towards the MIPS Final Score
- The MIPS performance categories and their 2022 weights towards the final score are: Quality (30%); Promoting Interoperability (25%); Improvement Activities (15%); and Cost (30%). The final score (100%) will be the basis for the MIPS payment adjustment assessed for MIPS eligible clinicians. The following tables categorize the 2023 performance period MIPS quality measure inventory based on measure type and the Meaningful Measures 2.0 Framework Domains

Measure Type	Number of Measures (2023 Performance Period)
Patient Engagement/Experience	2
Efficiency	5
Intermediate Outcome	7
Outcome	33
Patient Reported Outcome-Based Performance Measure (PRO-PM)	17
Process	133
Structure	1
Total	**198**

Meaningful Measures 2.0 Priority	Number of Measures (2023 Performance Period)
Person-centered Care	33
Equity	1
Safety	37
Affordability and Efficiency	28
Chronic Conditions	44
Wellness and Prevention	23
Seamless Care Coordination	10
Behavioral Health	22
Total	**198**

**MIPS Meaningful Measures counts may shift as categorizations are finalized for 9 measures new in 2023.*

Quality – MIPS

High Priority Areas for Future Measure Consideration:

The following specialties, clinical conditions, and topics have been identified as gaps within the MIPS quality performance category and are considered priority areas for future measure consideration.

Specialties:

- Interventional Cardiology
- Non-Patient Facing (i.g., Pathology, Radiology)
- Dentistry
- Podiatry
- Nutrition/Dietician
- Pain Management
- Plastic Surgery
- Hospitalists
- Nephrology
- Pulmonology
- Radiation Oncology
- Speech Language Pathology

Clinical Conditions:

- Opioid Epidemic
- Maternal Health
- Mental and Behavioral Health
- Chronic Conditions
  - Arrhythmias
  - Chronic Obstructive Pulmonary Disease
  - Hepatitis B
  - Septicemia
  - Respiratory Failure
  - Ashma
- Avoidance of Amputation for Diabetes
- "Age Friendly" (Older Adult/Geriatrics)
- Cardiovascular, including Hypertension
- Kidney Care and Organ Transplantation
- Sickle Cell Disease
- HIV and Hepatitis C
- Cancer
- Oral Health

Topics:

- Outcome Measures (outcome, intermediate outcome, and patient reported outcome measures (PRO-PMs) (patient voice))
- Coordination/Communication/Team-Based Care
- Interoperability/Digital Measures (i.e., quality measures with sources from administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, wearable/medical instruments, patient portals or applications, health information exchanges (HIEs) or registries, and other sources)
- Measures that provide new measure options within a topped-out specialty area
- Health Equity
- COVID-19
- Shared Decision-Making (patient voice)

CMS identifies the following as high priority MIPS quality measures for future consideration:

- Patient Experience: The measure should address the experience of each person and their family; and the extent to which they are engaged as partners in their care
- Care Coordination: The measure must address the promotion of effective communication and coordination of care; and coordination of care and treatment with other providers
- Efficiency: The measure must address the affordability of health care including unnecessary health services, inefficiencies in health care delivery, high prices, or fraud. Measures should cause a change in efficiency and reward value over volume
- Patient Safety: The measure must address either an explicit structure or process intended to make care safer, or the outcome of the presence or absence of such a structure or process; and harm caused in the delivery of care. The structure, process, or outcome must occur as a part of or because of the delivery of care
- Appropriate Use: CMS wants to specifically focus on appropriate use measures. The measure must address appropriate use of services, including measures of over-use
- Opioid Related: CMS wants to focus on opioid related measures to address the national Opioid Epidemic
- Health Equity
- CMS prioritizes quality measures that:
    - Provide new measure options within a topped-out specialty area
    - Reduce reporting burden – includes digital quality measures (dQMs), administrative claims measures and measures that align across programs
    - Capture relevant specialty clinicians
    - Reflect the quality of a group's overall health and wellbeing including access to care, coordination of care and community services, health behaviors, preventive care screening, and utilization of health care services
    - Support health equity

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Merit-based Incentive Payment System. At a minimum, the following requirements must be met for consideration in the program:

1. CMS is statutorily required to select measures that reflect consensus among affected parties, and to the extent feasible, include measures set forth by one or more national Consensus-Based Entities

2. Candidate measures should align with the Meaningful Measures 2.0 Framework and address at least one of the CMS Healthcare Priority Areas
3. Before including a new measure in MIPS, CMS is required to submit the measure for publication in an applicable specialty-appropriate, peer-reviewed journal and the method for developing the measure, including clinical and other data supporting the measure. The Peer-Review Journal Article Template provided by CMS, must accompany each measure submission. Please review the Peer-Review Journal Article Template for additional information available on the Pre-Rulemaking Resources | The Measures Management System (cms.gov)
4. Measures submitted should be linked to a Cost Measure, Improvement Activity, and/or an applicable MVP
5. Measures implemented in MIPS may be available for public reporting on *Care Compare*.
6. Measures are preferred to be fully developed, with completed testing results at the clinician level (and group level as appropriate) and ready for implementation at the time of submission (CMS' internal evaluation)
7. Measures should include testing data to support the MIPS collection type to be used for reporting (MIPS clinical quality measure (CQM), Administrative Claims, or electronic clinical quality measure (eCQM)). If the measure is being submitted 12 for implementation as multiple MIPS collection types, testing data submitted should meet the requirements for each applicable MIPS collection type
8. Preference will be given to measures that are endorsed by a CMS Consensus-Based Entity (CBE)
9. Measures should not duplicate other measures currently in MIPS. Duplicative measures are assessed to see which would be the better measure for the MIPS measure set
10. Measure performance data from testing and research evidence should identify opportunities for improvement. CMS does not intend to implement measures in which evidence identifies high levels of performance with little variation or opportunity for improvement, i.e., measures that are "topped out."
11. eCQMs must meet electronic health record (EHR) system infrastructure requirements, as defined by MIPS regulation

Cost – Merit-based Incentive Payment System

High Priority Areas for Future Measure Consideration

- The specialties below are those which have limited applicability from the current MIPS episode-based cost measures
    - Anesthesiology
    - Audiology
    - Certified Nurse Midwife
    - Certified Registered Nurse Anesthetist (CRNA)
    - Dentist
    - Diagnostic Radiology
    - Hand Surgery
    - Maxillofacial Surgery
    - Nuclear Medicine
    - Obstetrics/Gynecology
    - Optometry
    - Oral Surgery (dentists only)
    - Pathology
    - Podiatry
    - Radiation Oncology
    - Registered Dietician/Nutrition Professional
    - Speech Language Pathology
- These were identified from empirical analyses using administrative claims data. The list of specialties represents those where the specialty has <10% of clinicians who are attributed at least 1 episode. This analysis is on 2019 data and does not apply restrictions for MIPS participation[1]
- While the global cost measures may apply to these specialties, we nonetheless include the specialties here as many stakeholders have expressed interest in having measures focused on types of care in addition to the broad, population-based measures

[1] Centers for Medicare & Medicaid Services. (2022). *CMS for CMS 2022 Call for Cost Measures Fact Sheet for details about the methodology* [Fact sheet]. U.S. Department of Health & Human Services. https://www.cms.gov/files/document/mips-call-cost-measures-overview-fact-sheet-2022.pdf

Measure Requirements

CMS applies criteria for measures that may be considered for potential inclusion in Merit-based Incentive Payment System (MIPS) Cost Measures. At a minimum, the following requirements (questions) must be met for consideration in the program:

1. Is the measure based on measure specifications that have clinical face validity? Are the specifications consistent with practice standards?
2. Does the measure have clear, attribution to clinicians? Could clinicians anticipate when their responsibility for a patient begins under the measure?
3. Does the measure include the cost of services that reflect the role of attributed clinicians?
4. Is the construction methodology readily understandable to clinicians?
5. Can the measure be presented in a way that conveys clear information on how clinicians can alter their practice to improve measured performance?
6. Do the measure specifications allow for consistent calculation and reproducibility using Medicare claims data?
7. Does the testing information in the submission demonstrate variation to help distinguish cost performance across individual clinicians?
8. Can the measure be used in an existing or future potential MVP to assess the value of care for a defined clinical topic?
9. CMS will also consider the extent to which the measure shares the same components as current MIPS cost measures and any other factors as appropriate. This helps to promote consistency within the MIPS cost performance category

MIPS Value Pathways (MVPs) Development Criteria:

CMS applies criteria for measures that may be considered for potential adoption in the Merit-based Incentive Payment System (MIPS) Value Pathways. If applicable and feasible, use measures and improvement activities across all 4 performance categories, (quality, cost, improvement activities, and Promoting Interoperability). At a minimum, the following requirements must be met for consideration in the program:

1. Have a clearly defined intent of measurement
2. Align with the Meaningful Measure Framework
3. Have measure and activity linkages within the MVP
4. Be clinically appropriate for the MVP under development
5. Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties

6. Be understandable by clinicians, groups, and patients
7. To the extent feasible, include electronically specified quality measures
8. Incorporate the patient voice (patient reported outcome-based performance measure or shared decision-making measure)
9. Support health equity

Part C and D Star Ratings

Program History and Structure:

- The Part C & D Star Ratings program is based on sections 1851(d), 1852(e), 1853(o) and the 1854(b)(3)(iii), (v), and (vi) of the Social Security Act
- General authority under section 1856(b) of the Act: establishment of standards consistent with and to carry out Part C & D as basis for the 5-Star Ratings system
- The methodology for the Part C & D Star Ratings program was codified in contract year (CY) 2019 Medicare Part C and D Final Rule
- CMS must propose through rulemaking any changes to the methodology for calculating the Star Ratings, the addition of new measures, the removal of a measure within the Star Ratings, and substantive measure changes per §423.184 and §422.164
- Non-substantive measure specification changes for the Star Ratings will be announced through the advance notice process per §423.184(d)(1) and §422.164(d)(1)
- The Star Ratings Program is consistent with CMS's Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:
    - Safety, person and caregiver-centered experience and outcomes, care coordination, clinical care, population/community health, efficiency and cost reduction
    - CMS highlights contracts receiving an overall rating of 5 stars with the High Performing Icon (HPI) on the MPF:
        - Beneficiaries may enroll in a 5-Star PDP, MA-PD, or MA-only plan through a Special Election Period (SEP). 5-Star Plans may market year-round
- Beneficiaries may not enroll online via the MPF in a Low Performing Icon (LPI) plan. Beneficiaries must contact the plan directly
    - The LPI Icon is displayed for contracts rated less than 3 stars for at least the last 3 years in a row for their Part C or D summary rating

- Beneficiaries in LPI plans are eligible for a Special Enrollment Period (SEP) to move to a higher quality plan

- Per the Affordable Care Act, CMS makes Quality Bonus Payments (QBPs) to MA organizations that meet quality standards measured using a five-star quality rating
- The QBP percentage for each Star Rating for 2020 payments:

Star Rating	QBP Percentage
3.5 stars or below	0%
4 stars or more	5%

- The MA rebate level for plans is tied to the contract's Star Rating

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	5
Outcome	2
Patient Reported Outcome-Based Performance Measure (PRO-PM)	8
Process	26
Structure	0
Total	**41 (38 unique measures)**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	18
Equity	0
Safety	2
Affordability and Efficiency	1
Chronic Conditions	9
Wellness and Prevention	4
Seamless Care Coordination	4
Behavioral Health	0
Total	**38**

High Priority Areas for Future Measure Consideration:

- **Management of Chronic Conditions**: The Medicare population includes many individuals and older adults with high-risk multiple chronic conditions who often receive care from multiple providers and settings which can subsequently lead to fragmented care and adverse healthcare outcomes. Using evidence-based clinical practice guidelines, high priorities for the program include:
  - Improving the coordination of care for Medicare beneficiaries
  - Improving medication management for Medicare beneficiaries
- **Equity of Care**: to incentivize Part C and D contracts to perform well for socially at-risk enrollees
- **Functional Outcomes**
- **Prevention and Treatment of Opioid Use Disorders**

High Priority Areas for Future Measure Consideration for Part C:

- **Promote Effective Prevention and Treatment of Chronic Disease**
  - One primary goal is to focus attention on preventing and treating chronic disease.
  - Kidney Health Evaluation for Patients with Diabetes (KED)
    - At the contract-level, this measure assesses the percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
  - This measure was created based on recommendations by the National Kidney Foundation (NKF) and the members of NCQA's Technical Expert Panel to focus on chronic kidney disease (KD) evaluation for diabetic patients.
  - This effort aligns with the NKF's development of a clinician-level kidney health evaluation measure that aims to improve CKD testing for American adults with diabetes.

High Priority Areas for Future Measure Consideration for Part D:

- **Promote Effective Communication of Coordination of Care**
  - A primary goal is to coordinate care for beneficiaries in the effort to provide quality care.
- **Promote Effective Prevention and Treatment of Chronic Disease**
  - Another primary goal is to focus attention on preventing and treating chronic disease.

Measure Requirements:

In addition to rulemaking, the following guiding principles are used in making enhancements and updates to the Part C and D Star Ratings program:

1. Ratings align with the current CMS Quality Strategy
2. Measures developed by consensus-based organizations are used as much as possible
3. Ratings are a true reflection of plan quality and enrollee experience; the methodology minimizes risk of misclassification
4. Ratings are stable over time
5. Ratings treat contracts fairly and equally
6. Measures are selected to reflect the prevalence of conditions and the importance of health outcomes in the Medicare population
7. Data are complete, accurate, and reliable
8. Improvement on measures is under the control of the health or drug plan
9. Utility of ratings is considered for a wide range of purposes and goals
    a. Accountability to the public
    b. Enrollment choice for beneficiaries
    c. Driving quality improvement for plans and providers
10. Ratings minimize unintended consequences
11. Process of developing methodology is transparent and allows for multi-stakeholder input

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

Program History and Structure:

- Section 3005 of the Affordable Care Act added subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act
- Section 1866(k) of the Social Security Act established a quality reporting program for hospitals described in section 1886(d)(1)(B)(v), referred to as a "PPS-Exempt Cancer Hospitals," or PCHs
    - These hospitals are excluded from payment under the inpatient prospective payment system (IPPS)

- PCHQR is a voluntary quality reporting program, in which data will be publicly reported on the Provider Data Catalog website (PDC)
  - If a PCH participates in the program, the facility is required to submit data for selected quality measures to CMS
  - There are no payment implications for PCHs related to the PCHQR program

Current Measure Information:

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	2
Outcome	8
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	5
Structure	1
Total	**16**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	6
Equity	0
Safety	6
Affordability and Efficiency	0
Chronic Conditions	2
Wellness and Prevention	2
Seamless Care Coordination	0
Behavioral Health	0
Total	**16**

High Priority Areas for Future Measure Consideration:

- **PRO-PM**
- **Care Coordination**
- **Behavioral Health**

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program. At a minimum, the following requirements must be met for consideration in the program:

1. Measure is responsive to specific program goals and statutory requirements
2. Measure specifications must be publicly available
3. Measure steward will provide CMS with technical assistance and clarification on the measure as needed
4. Promote alignment with specific program attributes and across CMS and HHS programs
5. Potential use of the measure in a program does not result in negative unintended consequences
6. Measures are preferred to be fully developed and tested, preferably in the PCH environment
7. Measures must be feasible to implement across PCHs
8. Measure addresses an important condition/topic with a performance gap and strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more appropriate costs
9. CMS has the resources to operationalize and maintain the measure

Rural Emergency Hospital Quality Reporting Program

Program History and Structure:

- A new quality reporting program for Rural Emergency Hospitals (REHs), a new Medicare provider type, is being implemented by the Centers for Medicare and Medicaid Services (CMS)
- The REH Quality Reporting Program seeks to gather and publicly report information on care provided by these hospitals so that such information is available to inform patient choice for choosing where to obtain care; as well as, toward improving quality and efficiency of care
- Quality measure information collected through the REHQR Program will be publicly reported

- Initial program implementation was initiated through rulemaking in the CY 2023 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Payment System Final Rule

What hospitals can become an REH:

Section 1861 (kkk)(7) of the Social Security Act, as added by Division CC, section 125, of the Consolidated Appropriations Act (CAA), defines an REH as a facility that, as of December 27, 2020, was:

1. a critical access hospital (CAH); or
2. a subsection (d) hospital with not more than 50 beds that was treated as being in a rural area pursuant to section 1886(d)(8)(E) of the Social Security Act.

For CY 2023, CAHs and subsection (d) hospitals eligible to convert to an REH may do so beginning January 3, 2023. Once converted, the REH may receive the adjusted payment fee schedule.

CMS is required to set up REH quality data requirements; REHs are required to submit such data:

- Under section 1861(kkk)(7) of the Act, as added by section 125 of Division CC of the CAA, the Secretary is required to establish quality measurement reporting requirements for REHs, which may include the use of a small number of claims-based measures or patient experience surveys. An REH must submit quality measure data to the Secretary, and the Secretary shall establish procedures to make the data available to the public on a CMS website
- Per the initial set up requirements, a data submission account with the Hospital Quality Reporting Secure Portal and a Security Official to oversee that account are required. If an account already exists for the hospital, this existing account may be used; however, the account will need to be updated with any new REH Medicare identifier. Requirements for quality measure specifications and quality reporting will be available in the near future through rule making. Note that there is no statutory language regarding payment and REH quality reporting

High Priority Measures Areas for Future Consideration

High priority measure areas for quality measures appropriate to the REH setting for future consideration are:

1. Outpatient procedures including diagnostic procedures
2. Patient Safety
3. Telehealth

4. Maternal Health
5. Behavioral Health
6. Emergency Department Services
7. Equity

No measures are currently adopted for the REHQR Program. The intent is to include measure considerations in the upcoming CY 2024 OPPS/ASC proposed rule scheduled for public display on July 1.

Measures Requirements

1. The number of hospitals that convert to an REH and their characteristics may inform the selection of quality measures as measures that are useable by REHs and that have sufficient numbers of REHs with sufficient volume of services to have meaningful measurement for individual facilities and, importantly, the public, are sought
2. It is essential that a concise set of important, impactful, reliable, accurate, and clinically relevant measures for REHs that would inform consumer decision-making regarding care and further quality improvement efforts in the REH setting

Skilled Nursing Facility Quality Reporting Program

Program History and Structure:

- The Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) was established in the Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS) Final Rule, as authorized by the Improving Medicare Post-Acute Care Transformation Act of 2014
- The SNF QRP is a pay for reporting program. SNFs must submit standardized patient assessment data with regard to quality measures and standardized patient assessment data elements
- Any SNF who does not meet reporting requirements may be subject to a two-percentage point (2%) reduction in their Annual Payment Update

Current Measure Information:

- There are 16 SNF QRP measures, the majority of which are required by statute

These are derived from the Minimum Data Set (MDS), the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN), and Medicare Fee-For-Service claims.

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	1
Intermediate Outcome	0
Outcome	9
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	6
Structure	0
Total	**16**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	5
Equity	0
Safety	4
Affordability and Efficiency	3
Chronic Conditions	0
Wellness and Prevention	2
Seamless Care Coordination	2
Behavioral Health	0
Total	**16**

High Priority Areas for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity

Measure Requirements:

CMS applies criteria for measures that may be considered for potential adoption in the Skilled Nursing Facility Quality Reporting Program (SNF QRP). For the SNF QRP, The IMPACT Act requires the development and reporting of quality measure addressing 5 domains in addition to resource use, hospitalization, and discharge to the community. These domains and categories are listed below. At a minimum, the following requirements must be met for consideration in the program:

1. Quality Measure Domains:
    a. Skin integrity and changes in skin integrity
    b. Functional status, cognitive function, and changes in function and cognitive function
    c. Medication reconciliation

d. Incidence of major falls

e. Transfer of health information and care preferences when an individual transitions.

2. Resource Use and Other Measure Domains:

   a. Resource use measures, including total estimated Medicare spending per beneficiary

   b. Discharge to community

   c. All-condition risk-adjusted potentially preventable hospital readmissions rates

3. Quality measures selected for the SNF QRP must be endorsed by the NQF unless they meet the statutory criteria for exception

4. Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and/or more affordable care

5. Measure reporting is feasible to implement, and measures have preferably been fully developed and tested

6. Measure results and performance should identify opportunities for improvement

7. Potential use of the measure in a program does not result in negative unintended consequences (e.g., overuse or inappropriate use of care or treatment, limiting access to care)

8. Measures adopted in the SNF QRP are publicly reported on *Care Compare*

Skilled Nursing Facility Value-Based Purchasing Program

Program History and Structure:

- The Protecting Access to Medicare Act (PAMA) of 2014 established the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program
- The SNF VBP Program rewards incentive payments to SNFs per the quality of care provided to Medicare beneficiaries
  - The SNF VBP Program measures quality of care with a single all-cause hospital readmission measure through FY 2024, as mandated by statute
- CMS withholds 2 percent of SNF Medicare FFS payments to fund the Program, and 60 percent of these withheld funds are redistributed to SNFs in the form of incentive payments
  - The SNF VBP Program began awarding incentive payments to SNFs on October 1, 2018

Expanded SNF VBP Program:

- Consolidated Appropriations Act, 2021, authorizes the Secretary to, with respect to payments for services furnished on or after October 1, 2023, apply up to 10 additional measures determined appropriate by the Secretary, which may include measures of:
  - Functional Status
  - Patient Safety
  - Care Coordination
  - Patient Experience
- In addition to the above measurement areas, and the aim to minimize burden, CMS may consider measures where SNFs and nursing homes are largely familiar with through the SNF Quality Reporting Program, Five-Star Quality Rating System, and/or the Nursing Home Quality Initiative

Current Measure Information:

- There are currently 4 SNF VBP measures
- These are derived from the Minimum Data Set (MDS), the Payroll Based Journal (PBJ), and Medicare Fee-For-Service claims data

Measure Type	Number of Measures
Composite	0
Cost/Resource Use	0
Intermediate Outcome	0
Outcome	3
Patient Reported Outcome-Based Performance Measure (PRO-PM)	0
Process	0
Structure	1
Total	**4**

Meaningful Measures 2.0 Priority	Number of Measures
Person-centered Care	0
Equity	0
Safety	2
Affordability and Efficiency	2
Chronic Conditions	0
Wellness and Prevention	0
Seamless Care Coordination	0
Behavioral Health	0
Total	**4**

High Priorities for Future Measure Consideration:

- **Health Equity**: Develop and adopt measures which focus on health equity

For more information, email the Measure Management Support Team at MMSSupport@battelle.org