CMS Quality Strategy
2016

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Overview

The Centers for Medicare & Medicaid Services (CMS), in collaboration with public and private partners, is transforming how we conduct business and operations, connect providers, and empower consumers and beneficiaries. We are working to build a health care delivery system that's better, smarter and healthier—a system that delivers improved care, spends health care dollars more wisely, and one that makes our communities healthier. CMS is striving to support the delivery of consistent high-quality care, promote efficient outcomes in our health care system, and ensure that health insurance remains affordable for the millions of Americans seeking and receiving coverage. We are using all our policy levers and program authorities (see below) to achieve these goals while rewarding innovation in the delivery of services, implementing initiatives to reduce provider burden, and employing state-of-the-art technologies to assure program integrity.

Driving quality improvement is a core function of CMS. This commitment is evident as CMS enhances its partnerships in a delivery system where providers are supported in achieving better outcomes in health and health care at lower cost for the beneficiaries and communities they serve. CMS must strategically implement these efforts to ensure that providers meet their goals, quality of life improves for beneficiaries and consumers, and patients receiving care are healthy and safe.

The CMS Quality Strategy guides the activities of all agency components working together toward transformation. It builds on the foundation of the CMS Strategy and the HHS National Quality Strategy for Improvement in Health Care (NQS). The National Quality Strategy was developed through a participatory, transparent, and collaborative process with input from a wide array of stakeholders, led by the Agency for Healthcare Research and Quality, and is updated annually in a report to Congress.

Introduction

Federal, state, and local governments, businesses, providers, and advocates are working together to build a better health care system. Quality care can increasingly be affordable care and in working together, everyone can benefit. From finding common ground on best practices to collaborating for better outcomes across sectors and across the nation, health care stakeholders are ready to get this work done. CMS's vision is to seize this moment to transform the health care system into one that works every time, for every American. This transformed system aims to deliver better care, spend our health care dollars in a smarter way, and put consumers at the center of care to keep them engaged and healthy.

Consumers are demanding better ways to manage their own health, and seek transparency in how they find health care plans and what health care costs their plans will cover. Many activities will contribute to transformation of the current system, including changing the way CMS pays providers to incentivize quality instead of quantity. Smarter payments will help cut down on inefficiencies and the overuse of costly tests and other diagnostics. Better organization and use of data and health information, including the use of electronic health records (EHR) and other health information technology (health IT) resources, will help providers and consumers communicate more easily and make informed decisions. Giving consumers access to their records enables them to be more active participants in their care, making care more person-centered.

The Affordable Care Act (ACA) continues to increase access to high-quality, affordable health care for all Americans, including better access to coverage for persons with pre-existing conditions and young adults, as well as expanded access to preventive services. The National Quality Strategy articulates broad aims and priorities that have guided the development of HHS and CMS programs, regulations, and strategic plans for new initiatives, and serves as a critical tool for evaluating the full range of federal health care efforts. It has been the impetus for planning across HHS to establish mechanisms to obtain additional private sector input on specific goals, benchmarks, and quality metrics. Successful implementation of the National Quality Strategy and the CMS Quality Strategy envisions health and care that is person-centered, provides incentives for the right outcomes, is sustainable, emphasizes coordinated care and shared decision-making, and relies on transparency of quality and cost information.

It promotes alternative payment models, including Accountable Care Organizations (ACOs) and episode-based payments, value-based purchasing, integrated care, and medical and health homes. In January 2015, The Administration set goals for value-based payments within the Medicare Fee-for-Service (FFS) system and invited private sector payers to match or exceed them:

- **Goal 1:** 30% of Medicare payments are tied to quality or value through alternative payment models by the end of 2016, and 50% by the end of 2018.

- **Goal 2:** 85% of all Medicare FFS payments are tied to quality or value by the end of 2016, and 90% by the end of 2018.

The CMS Quality Strategy pursues and aligns with the broad aims of the National Quality Strategy as well as the Administration's strategy for shifting Medicare payments from volume to value:

- **Better Care:** Improve the overall quality of care by making health care more person-centered, reliable, accessible, and safe.
- **Smarter Spending:** Reduce the cost of quality health care for individuals, families, employers, government, and communities.
- **Healthier People, Healthier Communities:** Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.

To advance its three aims, the National Quality Strategy identified six priorities:

1. Making care safer by reducing harm caused in the delivery of care;
2. Ensuring that each person and family is engaged as partners in their care;
3. Promoting effective communication and coordination of care;
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
5. Working with communities to promote wide use of best practices to enable healthy living; and
6. Making quality care more affordable for individuals, families, employers, governments, and communities by developing and spreading new health care delivery models.

These priorities map to the three National Quality Strategy aims and are goals in the CMS Quality Strategy. This document identifies quality-focused objectives that CMS can drive or enable to further these goals. Quality interventions are inherently interrelated, and many goals include concepts that could be articulated under more than one goal. We organized and structured objectives based on where the primary driver of change occurs.

Organizational Tenets

Vision

The vision of the CMS Quality Strategy is to optimize health outcomes by improving quality and transforming the health care system.

Mission

CMS serves the public as a trusted partner with steadfast focus on improving outcomes, beneficiary/consumer experience of care, population health, and reducing health care costs through improvement. To maintain this focus, we will:

- Lead quality measurement alignment, prioritization, and implementation and the development of new, innovative measures;
- Guide quality improvement across the nation and foster learning networks that generate results;
- Reward value over volume of care;

- Develop, test, and implement innovative delivery system and payment models to improve care and lower costs;
- Collaborate across CMS, HHS, and with external stakeholders;
- Listen to the voices of beneficiaries, patients and their families, consumers, and those who provide health care in all settings;
- Foster an environment that creates the capacity for state Medicaid/CHIP agencies and health plans to improve quality through use of locally generated data and local innovations in care delivery;
- Be a model of effective business operations, customer support, and innovative information systems that excel in making meaningful information available; and
- Develop CMS staff, create high-functioning teams, foster pride and joy in work at all levels, continuously learn, and strive to improve.

Values

The CMS Quality Strategy aligns with the CMS Organizational Strategy's values, and we commit our work to:

- **Beneficiaries and Consumers Come First** – We put first the best interest of the people we serve.
- **Public Service** – We take pride in our unique and privileged role in the health care of the nation.
- **Integrity** – We hold ourselves to the highest standards of honesty and ethical behavior.
- **Accountability** – We earn trust by being responsible for the outcomes of our actions.
- **Teamwork** – We foster unconditional teamwork and regard every employee in CMS as available and willing to help others.
- **External Collaboration** – We strive to work in full cooperation with the private sector.
- **Innovation** – We encourage finding and testing new ideas in all that CMS does.
- **Excellence** – We are committed to strengthening our organizational culture of striving for excellence in our products, services, and how we do business.
- **Respect** – We treat all our stakeholders and one another with the utmost respect and professionalism.

We strive to continually refine our processes, systems, and services for the benefit of internal and external stakeholders. Throughout our work to improve quality, we will: seek input and actively listen, collaborate, and partner with stakeholders outside CMS; be responsive to beneficiary and provider needs; learn from others and foster learning networks; be a catalyst for health system improvement; and focus on what is best for health care consumers, as well as their individual goals.

The CMS Quality Strategy Goals

This Quality Strategy delineates objectives and outcomes to guide action to realize six broad and interrelated goals. The CMS Quality Strategy goals reflect the six priorities set out in the National Quality Strategy:

- **Goal 1:** Make care safer by reducing harm caused in the delivery of care.
- **Goal 2:** Strengthen person and family engagement as partners in their care.
- **Goal 3:** Promote effective communication and coordination of care.
- **Goal 4:** Promote effective prevention and treatment of chronic disease.
- **Goal 5:** Work with communities to promote best practices of healthy living.
- **Goal 6:** Make care affordable.

Foundational Principles

Four foundational principles guide CMS's action toward each of these goals. To ensure we actively address these principles, we will continuously evaluate how we embed the foundational principles within each goal.

1. Eliminate Racial and Ethnic Disparities

Health care disparities are the differences in health and health care between population groups. Despite progress in total population health, the gaps among racial and ethnic groups in the quality, experience, outcomes, costs of health care, and the social determinants of health must close at a faster pace. Communities of color experience poorer health outcomes, are less likely to have a usual source of care or receive routine preventive services, and have higher rates of morbidity and preventable conditions than non-minorities. Disparities in health care exist even when controlling for gender, condition, age, disability, socioeconomic status, and other factors.

Eliminating disparities is essential for improving the health care delivery system for all Americans. CMS is dedicated to helping eliminate disparities in health care by aligning to the HHS Action Plan to Reduce Racial and Ethnic Disparities. CMS is also committed to achieving health equity by improving data collection to better measure and analyze disparities across programs and policies. As part of these efforts, CMS is promoting culturally and linguistically appropriate care for all beneficiaries, as well as health literacy to help people navigate the health care system effectively.

There is a need for all providers to work actively to continuously monitor and address disparities, and to be accountable for reducing gaps in care and outcomes. All CMS beneficiaries must have access to and receive person-centered, equitable, effective, safe, timely, and efficient care and services.

2. Strengthen Infrastructure and Data Systems

Data and information are essential aspects of a healthy, robust health care infrastructure. Services, treatment, and care rely on various components of the health care system delivered at different levels. Health care is moving into the digital and "big data" world. With passage of the Heath Information Technology for Economic and Clinical Health Act, the nation's hospitals, clinics, and providers began transitioning to health IT in greater numbers. Providers are increasingly electronically accessing patient

records and histories tracking care, and making electronic records available to patients. This increase in data sharing and usage allows for greater innovation, helping us to better understand our country's health challenges and see the incredible potential for growth and change.

Strengthening infrastructure and data systems for public reporting and using electronic data collection are essential to all CMS activities. These efforts enhance the agency's ability to: monitor trends in critical health measures among priority populations; monitor health status, health care, and health policies at the national, state, local, and tribal levels; and conduct in-depth studies of population health at the community level, and for specific groups of individuals. A robust data infrastructure is also necessary to ensure transparency of accurate quality and cost information. Increasingly, consumers and families rely on this information to make informed decisions when choosing a health care provider and/or health plan and to understand the types of available health care services. Payment programs and models recently implemented by CMS (e.g., the Medicare Shared Savings Program, the Medicare Fee-for-Service Physician Feedback Program/Physician Value-Based Payment Modifier, and Medicaid shared savings models) require new capacities in CMS information systems, including the ability to align programs and administer population- and value-based payments. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which will transform the way in which CMS pays clinicians, explicitly emphasizes expanded use of health IT and frequent data feedback to help clinicians deliver higher quality care. CMS is evolving its infrastructure and data systems to enhance transparency of quality and cost information and to allow for payment and management of accountable, value-based care. As examples, over the past two years, CMS has released unprecedented amounts of data providing insight into utilization trends and patterns among hospitals and physicians. CMS has also begun to transition to star ratings on all of its public reporting provider "Compare" websites to make quality of care more understandable to consumers and the public.

3. Enable Local Innovations

CMS promotes innovation at all levels of the health care system. The effectiveness of health care service delivery often depends on the availability and quality of social services and programs in a given community. Because each local community is unique, CMS will advance programs that allow communities to address their challenges in ways that best meet their needs. Improving access to essential services requires three forms of innovation: (1) *technological*, to ensure availability of services that are more cost effective than existing interventions; (2) *social*, to ensure the equitable distribution of essential services; and (3) *adaptive*, to involve both providers and communities to tailor the adoption of services to local settings.

4. Foster Learning Organizations

A learning organization is one that continually expands its ability to shape its future. For a modern, knowledge-based, service-focused agency like CMS to succeed, learning must be linked to the organization's strategic goals. CMS makes continual learning a routine activity to improve the performance of our entire organization as a total system.

CMS also recognizes the need to support learning across the health care system. As we introduce new programs requiring core competencies in health care improvement and population health, we are mindful of our role in providing educational support for providers, payers, and states. Education does not end when a provider receives credentials or a patient is discharged from an institutional setting to the community. Education is increasingly continuous, deliberate, and an integral part of organizational

learning. CMS is committed to promoting learning and education as key parts of its quality programs and delivery system reform initiatives. For example, CMS launched the Health Care Payment Learning and Action Network (LAN) in 2015. The goals of the LAN are to convene stakeholders to collaborate on generating and documenting evidence for best practices for moving to alternative payment models.

By fostering learning organizations, CMS will use funding more effectively and continue to explore the best methods for delivering health care and disseminating best practices.

Drivers and Policy Levers

CMS is working to achieve these objectives through multiple drivers and policy levers of quality, including, but not limited to:

- Measuring and publicly reporting providers' quality performance and cost of services provided;
- Providing technical assistance and fostering learning networks for quality improvement;
- Adopting evidence-based National Coverage Determinations;
- Creating incentives for quality and value
- Setting standards for providers that support quality improvement; and
- Creating survey and certification processes that evaluate capacity for quality assurance and quality improvement.

Agents and Partners

Many "agents" are necessary to shape initiatives and implement activities to further the goals and objectives in this Strategy, including CMS, state Medicaid /CHIP agencies; other federal, state, tribal, and local governmental organizations; and health providers. CMS is both a driver and enabler of activities while other federal agencies, state Medicaid agencies, health care organizations, providers, advocacy groups, and academia play critical roles in improving the quality of health care for all Americans.

CMS

CMS plays two roles in implementing this Quality Strategy: driver and enabler. In some instances, CMS has the capacity to directly drive or implement changes to payments, regulations, and improve transparency in service of the quality improvement objectives outlined in this Strategy. In other cases, CMS can enable external agents such as health systems, hospitals, practitioners, and community providers to implement initiatives and activities by supporting demonstration projects, developing educational materials and guidance, and facilitating the exchange of promising practices through learning and action networks. This Strategy presents CMS-driven and CMS-enabled initiatives together.

Partners

To achieve its goals, CMS forges partnerships among federal, state, territorial, tribal, and local governments; business, industry, and other private sector partners; professional philanthropic organizations; community and faith-based organizations; and citizens

CMS also works closely with state Medicaid/CHIP agencies that partner in financing and implementing health care programs. Private sector insurers are key partners that often model their approaches to payment and delivery on CMS approaches. We continue relationships with these public and private

sector payers to leverage the impact of new payment models and quality improvement best practices across settings of care.

CMS components also coordinate efforts with other federal entities through quality initiatives and issue-based workgroups. These partners and workgroups include the Quality Improvement Council (QIC), the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH) the Veterans Health Administration (VHA), Centers for Disease Control and Prevention (CDC), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Medicare Payment Advisory Commission (MedPAC), the CMS Office of Legislation (OL), the Office of the National Coordinator for Health Information Technology (ONC), and the Administration for Community Living (ACL). CMS components also work closely with non-governmental organizations to strive for better care throughout the health care system, such as The Joint Commission, National Quality Forum (NQF), National Committee for Quality Assurance (NCQA), American Medical Association (AMA), and American Hospital Association (AHA). In 2015, CMS established a number of "affinity groups" within the agency to focus groups of individuals interested in and working on particular topics (e.g., Alzheimer's Disease and Related Dementias (ADRD), Care Coordination, Person and Family-Centered Care) to better align and focus our work.

Goal 1: Make care safer by reducing harm caused in the delivery of care

Strategic Result: Health care-related harms are reduced.

Health care-related errors harm millions of Americans each year and add billions of dollars to health care costs. Two prominent examples involve infections and medications: The CDC estimates that at least 1.7 million health care-associated infections occur each year, leading to 99,000 deaths, while adverse medication events cause more than 770,000 injuries and deaths each year. The cost of treating patients harmed by these events is estimated at $5 billion annually.[1]

CMS strives to make care safer by supporting a culture of safety, eliminating inappropriate and unnecessary care that can lead to harm, and reducing rates of health care-acquired conditions (HACs) in all health care settings (see National Action Plan to Prevent Healthcare-Associated Infections: Road Map to Elimination). We can achieve these objectives through improved communication among patients, families, and providers; empowering patients to become more engaged in their care; better coordination of care within and across settings; and broad implementation of evidence-based safety best practices wherever care is provided. Payment systems that incentivize smarter use of tests and treatments will minimize the harm that can result from inappropriate care.

Through programs and initiatives such as section 1115 Medicaid demonstration waivers, Value-Based Purchasing (including Hospital VBP), Medical and Health Homes, Medicare Advantage Quality Bonus Payments, and the End-Stage Renal Disease Quality Incentive Program, CMS provides financial incentives that reward providers for adopting best practices that can decrease harm. CMS also provides opportunities for providers to work together through Quality Improvement Organizations (QIOs), Partnership for Patients, and the Transforming Clinical Practice Initiative (TCPI). These initiatives help to diffuse and promote the systematic use of best practices that emphasize quality improvement and patient safety, thus accelerating the rate of adoption of new knowledge in the delivery system. CMS also assures patients' safety through its survey and certification authority by assessing compliance with federal health and safety-related standards, including those related to quality assessment and performance improvement.

These strategies to achieve a safer health care system are working. These strategies to achieve a safer health care system are working. The final 2013 Annual Report of Hospital Acquired Condition Rate and Estimates, report released by the Department of Health and Human Services[2] shows an additional 9 percent decline in the rate of hospital-acquired conditions (HACs) from 2012 to 2013 over the interim rate of 17 percent, and a 17 percent decline, from 145 to 121 HACs per 1,000 discharges, from 2010 to 2013. A cumulative total of 1.3 million fewer HACs were experienced by hospital patients over the 3 years (2011, 2012, 2013) relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level. We estimate that approximately 50,000 fewer patients died in the hospital as a result of the reduction in HACs, and approximately $12 billion in health care costs were saved from 2010

[1] Agency for HealthCare Research and Quality, *AHRQ's Efforts to Prevent and Reduce Health Care-Associated Infections Fact Sheet:* http://www.ahrq.gov/research/findings/factsheets/errors-safety/haiflyer/index.html

[2] Agency for HealthCare Research and Quality, *2013 Annual Report of Hospital Acquired Condition Rate and Estimates,* http://www.ahrq.gov/professionals/quality-patient-safety/pfp/hacrate2013.html

to 2013. Although the precise causes of the decline in patient harm are not fully understood, the increase in safety has occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events, spurred in part by Medicare payment incentives and catalyzed by the U.S. Department of Health and Human Services Partnership for Patients initiative led by CMS.

CMS aims to partner with health care providers in a continual effort to reduce the risk for injury from care, aiming for zero harm whenever possible and striving to create a system that reliably provides high-quality health care for everyone. We believe this kind of system can make a substantial difference in improving care by preventing serious adverse medication events and eliminating health care-associated infections and other preventable conditions.

Goal 1 – Foundational Principles

Eliminate disparities

- Implement stratified reporting of quality measures by race, ethnicity, disability, and primary language.
- Educate health care professionals about health disparities and cultural and linguistic competencies as part of a curriculum to promote a culture of safety.
- Improve safety and reduce unnecessary and inappropriate care by teaching health care professionals how to better communicate with people of low health literacy and more effectively link health care decisions to person-centered goals.
- Promote the use of health care navigators and translation services in the cultivation of a culture of safety.
- Implement integrated care across various health care delivery settings, including the development of effective linkages to community resources.

Strengthen infrastructure and data systems

- Ensure that standardized race, ethnicity, gender, primary language, geographical (rural/urban), and disability information is collected to identify disparities in health care delivery outcomes.
- Use health IT (EHR, registries, and health information exchanges) to identify people at risk and improve safety across settings of care.
- Implement and test value-based and alternative payment models that link payment incentives to measures of safety and appropriateness.
- Link quality measurement to clinical decision support to promote provision of evidence-based care by providers and to reduce inappropriate use of medications, treatments, and diagnostics.
- Emphasize use of outcome-based measures of safety over process measures to encourage providers to innovate quality improvement practices to reduce or eliminate harm.

Enable local innovations

- Support the collection of data locally to identify and target issues of harm and inappropriately delivered care within a community or practice location.
- Support multi-stakeholder meetings that include local frontline providers, individuals, and families to identify innovative solutions to reduce harm in all settings.

Foster learning organizations

- Support health worker education about reducing inappropriate and unnecessary care, starting with treatments and tests highlighted in the Choosing Wisely® campaign, which promotes dialogue between practitioners and patients.
- Encourage multidisciplinary, cross-sector learning communities that bring together clinicians, other licensed providers, persons and families, community health workers, and other community stakeholders to disseminate best practices and learn from high performers.

Goal 1: Make care safer by reducing harm caused in the delivery of care

Objectives	Desired Outcomes
Improve support for a culture of safety	• Improved application of safety practices involve all team members, patients, and families and assure that individuals' voices are heard • Organizations exhibit strong leadership that educates and empowers the workforce to recognize harm and increase reporting of errors and potential errors • Consumers have increased access to understandable health Information • Expanded use of evidence-based services and primary care • Disparities in care are eliminated
Reduce inappropriate and unnecessary care	• Health care organizations continually assess adverse events in accordance with evidence-based practices • Health care cost reductions are attributable to the reduction of unnecessary, duplicative, and inappropriate care • Disparities in care are eliminated
Prevent or minimize harm in all settings	• HACs, Provider Preventable Conditions (PPCs) and health care- associated infections (HAIs) are reduced • Medication error rates are improved • Falls are decreased • Visibility of harm is improved in all settings • Expanded use of evidence-based services and primary care • Person and family access to understandable health information is increased • Disparities in care are eliminated

Goal 2: Strengthen persons and their families as partners in their care

Strategic Result: Persons and families are engaged as informed, empowered partners in care.

CMS is at the forefront of the nationwide effort to transform health care delivery to meet the individual's person-centered goals in creating a health care system that fully engages individuals and families in the design, delivery, and evaluation of care. *The CMS Quality Strategy uses "family" broadly to include non-medical participants in a person's health care.* For clinical purposes, the Institute of Medicine defines patient-centered care as "respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." The National Quality Forum defines person- and family-centered care as "an approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals, their defined family, and providers of care. It supports health and well-being by being consistent with, respectful of, and responsive to an individual's priorities, goals, needs, and values."

In addition to improving the individual's experience, studies have found that person-centered care models improve quality of care and health outcomes, engage people more actively in their health care, and can reduce costs and disparities in care.

A person-centered approach considers the individual as multifaceted, not merely as a "receiver" of services. For example, the Affordable Care Act requires that states receiving federal funds develop systems that are responsive to the needs and choices of beneficiaries receiving home and community-based services (HCBS), maximize independence and self-determination, and provide coordination to assist with achieving a community-supported life. This approach demands that providers and individuals share power and responsibility in goal setting, decision-making, and care management. It also requires giving people access to understandable information and decision support tools to equip them and their families with the information to manage their health and wellness, navigate the full span of the health care delivery system, and make their own informed choices about care.

As examples, CMS has embarked on QIO initiatives, such as the Everyone with Diabetes Counts program, which gives each person with diabetes and their family an active role in care. CMS is has also developed and tested various experience of care surveys, including those for people more difficult to query, such as persons using HCBS.

CMS aims to strengthen person and family engagement in health care by:

- Actively encouraging person and family engagement across the care continuum;
- Promoting tools and strategies that promote self-determination and achieve individuals' goals, values, and preferences, including self-managing and self-directing care;
- Creating an environment where the individual, as the center of the health care team, can create person-centered, strengths-based health and wellness goals that are accessible, appropriate, effective, sufficient, and aligned with the individual's values and preferences;
- Improving the experience of care for individuals and families by developing criteria for identifying person and family engagement best practices and techniques ready for widespread integration and scaling; and

- Working with partners to promote and support education and training of healthcare professionals to partner effectively with patients and families.

Goal 2 – Foundational Principles

Eliminate disparities

- Ensure the use of culturally, linguistically, and ability-appropriate consumer and family educational materials.
- Tailor self-management education and support programs to minorities and other vulnerable and underserved populations.

Enhance infrastructure and data systems across all settings of care

- Use health information technology (IT) to ensure communication and collaboration among providers, individuals, and families at the option of the person.
- Promote and support providers in creating health IT-enabled environments for persons engaged in the health care system.

Enable local innovations

- Encourage providers to develop innovative interventions to improve communication with persons and families.
- Incentivize health plans and providers to deploy effective person-centric tools and resources such as person-centered care plans.

Foster learning organizations

- Improve quality measurement and tools to measure person and family engagement.
- Promote transparency in access to quality health care data.
- Educate clinical providers about self-management best practices and how to teach these best practices to patients.

Goal 2: Strengthen person and family engagement as partners in care

Objectives	Desired Outcomes
Ensure all care delivery incorporates person and family preferences	• People are partners at all levels of care • Care, treatment, and services reflect the individual's personal values and goals • Coordination and communication occurs within and across care teams with the person at the center • Personal preferences are central in decision processes and implementation • There is team-based development of goals in plans of care • Information is updated and accessible for use by patients and families • Achievement of person-centered goals for health and wellness • Improved coordination and communication within and across organizations • Disparities in care are eliminated
Improve experience of care for persons and families	• Improved support for integrated care models • Expanded use of evidence-based services in all settings, including primary care • Increased access to understandable health information • Improved promotion of community-clinical partnerships and services aimed at managing and improving care at the local level • Expanded use of person experience of care survey results to identify best care and treatment practices
Promote self-management	• Improved application of self-management practices in CMS's programs • Improved visibility of self-management • Improved support for integrated care models • Increased access to understandable health information • Updated and available information for use by consumers and families • Improved patient confidence in managing multiple chronic conditions • A respectful, trustworthy, and transparent health care culture that establishes and sustains relationships

Goal 3: Promote effective communication and coordination of care

Strategic Result: Communication, care coordination, and satisfaction with care are improved.

Poor coordination of health care can result in medication errors; unnecessary procedures, treatment, and services; avoidable hospital admissions and readmissions; and other harms to health care patients. Most health care payment systems do not foster coordination of care or understanding of patient preferences, but instead pay for volume over value. Rewarding providers for performing more services, rather than for working together to support individuals' health goals and preferences, compromises their ability to achieve the best outcomes for individuals and communities.

Jencks et al. found that nearly 1 in 5 Medicare beneficiaries discharged from the hospital is readmitted within 30 days.[3] Medication errors and poor communication between providers in the inpatient setting and other post-acute care (PAC) settings (e.g., nursing homes, assisted living, and health homes) are some key drivers for readmissions within 30 days. Readmissions are also a major source of patient and family stress and may contribute substantially to loss of functional ability—a key quality indicator—particularly in older adults. Some readmissions are unavoidable and result from inevitable progression of disease or worsening of chronic conditions. Current readmission rates hover at 18.8 percent for Medicare and 14.4 percent for all payers. CMS estimates that readmissions within 30 days cost the Medicare program more than $17 billion annually[4].

Effective care coordination models deliver better health care quality at lower costs across all settings, from small physician practices to large hospital centers to community providers. Gaps and duplication in service delivery can be reduced or eliminated through the use of technologies, such as EHR and other health IT, electronic long-term services and support plans, e-prescribing, and telemedicine.

CMS encourages care coordination across the health care continuum so all health care patients receive seamless and more effective care. Hospitals, long-term care and rehabilitation facilities, and long-term care providers, including institutional and HCBS providers, are helping recently discharged patients avoid unnecessary re-hospitalization. CMS promotes a person-centered approach and recognizes the positive impact of having critical pieces of information communicated across all providers and settings of care.

Examples of CMS initiatives that further this goal include:

- Strengthening the hospital Conditions of Participation (CoP) for Discharge Planning to require more robust communication between acute and post-acute care settings;
- HHS's Partnership for Patients initiative, led by CMS;
- Advancing primary care services, medical homes, and health homes;
- Promoting the development of ACOs;
- Medicare and Medicaid Electronic Health Record Incentives Program (Meaningful Use);

[3] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med.* Apr 2 2009;360(14):1418-1428

[4] Centers for Medicare and Medicaid, Policy & Data Analytics Group, Office of Information Products and Data Analytics

- The 11th Scope of Work for CMS's Quality Innovation Network/Quality Improvement Organizations;
- Bundled payment initiatives;
- Financial alignment initiative to integrate care for Medicare-Medicaid enrollees;
- Per the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), to standardize patient assessment data to enable interoperability and facilitate care coordination, discharge planning, and improvements in quality and outcomes;
- Implementation of the Merit-based Incentive Payment System (MIPS), which emphasizes, among other focus areas, care coordination measures and clinical practice improvement activities;
- The State Innovation Models Initiative (SIM);
- Test Experience and Functional Tools (TEFT) grant program to field test an experience survey for HCBS and a set of functional assessment items, demonstrate personal health records, and develop a standard, electronic, long-term services and supports plan with the Office of the National Coordinator for Health Information Technology;
- Medicaid's Health Home State Plan benefit;
- Medicaid Innovation Accelerator Program support to states that are focused on improving care for beneficiaries with complex needs and high costs;
- Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents; and
- Medicare Advantage Organizations' (MAOs) Quality Improvement Projects (QIPs) focus on reducing all-cause hospital readmissions for MA enrollees.

When all health care providers coordinate efforts in a person-centered manner, it helps ensure that the individual is able to choose the services needed and control how and where they are delivered. Improved care coordination and communication across health care providers is essential to realizing better care, smarter spending, and healthier people. Individuals receiving care and their families also enjoy improved understanding of and satisfaction with care.

Goal 3 – Foundational Principles

Eliminate disparities

- Ensure that health information is culturally and linguistically appropriate and that patient and families understand and follow up appropriately on discharge instructions from an institutional setting.
- Enable effective health care system navigation by empowering persons and families through educational and outreach strategies that are culturally, linguistically, and health literacy-appropriate.
- Support a system that complies with the Americans with Disabilities Act, uses person-centered language, reinforces personal roles and empowerment, reflects independent living philosophies, and promotes recovery-oriented models for behavioral health services.

Enhance Infrastructure and data systems

- Build and apply data systems to facilitate coordination of care across the health care continuum, as well as to facilitate health and wellness of the individual.
- Use health IT to support effective health care system navigation for individuals and families and all other care partners.

Enable local innovations

- Encourage use of community health workers, resource coordinators, support brokers, individuals trained and/or certified in person-centered care planning, and other community-based professionals to support person and family activation, and health care system and community navigation.
- Promote the use of HCBS to maximize satisfaction, improve care transitions across settings, reduce long- and short-term institutionalization, and improve resource use.

Foster learning organizations

- Promote education and training for providers on effective techniques for communicating with individuals, their families and community resources.
- Promote education and training for consumers, their families, and community advocates on person-centered care and techniques for identifying and communicating with providers about their care needs and preferences.
- Encourage analysis of program performance data and use of Plan-Do-Study-Act (PDSA) models in the design and implementation of initiatives to reduce readmissions, improve care transitions, and innovate across community and institutional providers.
- Improve quality measurement of effective care transitions and promote transparency and access to data across settings.

Goal 3: Promote effective communication and coordination of care

Objectives	Desired Outcomes
Reduce admissions and readmissions	• Reduced admission and readmission rates through self-management, self-determination, and activation efforts • Patients are more satisfied with their ability to access their preferred setting of care • Increased health literacy rate • Survey results demonstrate measurable reduction in deficiencies related to discharge planning and transitions of care • Evidence-based best practices that promote appropriate discharge planning, care transitions, and support for community-based care are embedded in the routine practice of care across the health care continuum • Appropriate interventions prevent development of health conditions that require acute care such as HACS and PPCs • All partners in a particular community work in coordination to optimize care and services
Embed best practices to enable successful transitions between all settings of care	• Integrated, person-centered discharge tools are used across all settings • Patient activation efforts/self-management training are a standard part of clinical care • Improved patient experience with clinician awareness of other clinicians' recommendations • Reduced duplication of testing and other adverse outcomes due to lack of coordination • Community-based support systems and HCBS resources are integrated with clinical health care delivery (e.g., Aging and Disability Resource Centers, Area Agencies on Aging, Centers for Independent Living, and faith-based organizations) • improved patient experience with integration/coordination of care in ambulatory setting improved patient experience with integration/coordination of care in ambulatory setting

Objectives	Desired Outcomes
Enable effective health care system navigation	• Evidence-based best practices that enable patient activation/self-management are embedded in the routine practice of care (e.g., certified diabetes educators) • Improved patient experience with integration / coordination of care in ambulatory settings • Payer reimbursement is expanded beyond traditional patient education to include self-management education programs for people with multiple chronic conditions • Cross-setting, person-centered discharge planning tools that include person and family goals and preferences are routinely employed

Goal 4: Promote effective prevention and treatment of chronic disease

Strategic Result: Leading causes of mortality are reduced and prevented.

Chronic conditions last a year or more and require ongoing medical attention and/or limit activities of daily living. They include physical conditions such as arthritis, cancer, and HIV infection, as well as mental and cognitive disorders, such as ongoing depression, substance use disorders, and dementia. More than 133 million Americans report at least one chronic condition, while many have multiple chronic conditions (MCC)—two or more chronic conditions that affect a person at the same time. For example, a person with arthritis and hypertension and a person with heart disease and depression have multiple chronic conditions.[5]

Multiple chronic conditions are important because:

- MCCs are associated with approximately 66 percent of the total health care spending in the United States.
- As many as three out of four Americans aged 65 or older have MCC and approximately two out of three Medicare beneficiaries have MCC.
- Approximately one in four Americans in any age group has MCC, including one in 15 children.
- People with MCCs are also at increased risk for mortality and poorer day-to-day functioning.

When patients' numbers of chronic conditions increase, so do their risks for dying, additional hospitalizations that could be avoided, and possible conflicting treatment plans from physicians and other health care providers. MCC also contribute to frailty and disability. Functional limitations often complicate access to health care, interfere with self-management, and necessitate reliance on family and paid caregivers.

Increased spending on chronic conditions among Medicare beneficiaries is a key factor driving the overall increase in spending in the traditional Medicare program. Individuals with MCC face substantial out-of-pocket costs of their care and higher costs for prescription drugs.

As the health system feels the strain of treating and providing services to persons with chronic conditions, health care providers must do a better job preventing, screening for, and treating the leading causes of mortality and illness in adults and children. These include cardiovascular disease (CVD), cancer, stroke, diabetes, premature births, and behavioral health conditions.

To assist persons with chronic conditions (including those with MCC), CMS strives to make preventive health care services understandable, accessible, and affordable to increase health and well-being, and thus reduce health care costs. We strive to serve patients, beneficiaries, and other stakeholders by:

- Collaborating with providers, states, partner agencies, and stakeholder groups to increase awareness of current and new preventive health care services available to Medicare, Medicaid, and CHIP beneficiaries, and all Americans through the Health Insurance Marketplace;
- Raising the profile of identified preventive services that will have the greatest impact on improving beneficiary health;

[5] HHS Initiative on Multiple Chronic Conditions http://www.hhs.gov/ash/initiatives/mcc/

- Reducing disparities in access to and utilization of primary and specialty health care, preventive services, and reducing disparities in care for at-risk and special needs populations;
- Improving the use of data for monitoring and continuous improvement in population health by aligning population health programs and metrics for tracking prevention and treatment;
- Improving access to coordinated services so that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing;
- Testing and development of Innovation Center models that strengthen links between public health, clinical care, and community supports for health and wellness and aligned incentives;
- Creating access to information about public and private insurance options for persons seeking and receiving health care services; and
- Requiring Medicare Advantage Organizations (MAOs) to focus on promoting effective management of chronic diseases in their enrollee populations

For example, CMS is a lead partner in the Million Hearts® initiative, which seeks to reduce the incidence of heart attacks and strokes by 1 million by 2017. This will be accomplished by increasing awareness of the risk factors for cardiovascular disease and promoting and utilizing proven interventions. Decades of research and practice have demonstrated that public health and clinical preventive strategies can greatly reduce the risk of cardiovascular disease. The key interventions are referred to as the "ABCs": appropriate aspirin therapy, blood pressure control, cholesterol management, and smoking cessation.

CMS has incorporated prevention measures in our quality reporting programs including the Surviving Sepsis Campaign, Healthy People 2020, as well as screening and treatment for high blood pressure, high cholesterol, smoking cessation, and aspirin use for individuals with ischemic heart disease. Medicaid provisions such as Health Homes, Adult Medicaid Core Set of Quality Measures, and the Program for All-inclusive Care for the Elderly (PACE) (for Medicare and Medicaid enrollees) facilitate achievement of these goals. The Medicare-Medicaid Coordination Office focuses on improving care for the nearly 11 million Americans with complex needs enrolled in both programs; two thirds of this group are low-income older adults, and one third are people under 65 with diabetes.

Goal 4 – Foundational Principles

Eliminate disparities

- Coordinate with existing initiatives and focus new initiatives on improving access to utilization of preventive services in low-income and minority populations (e.g., self-management initiatives).
- Study effectiveness of prevention initiatives in minority communities, and other populations that experience health disparities.
- Promote data analysis strategies that support inclusion of data elements that demonstrate where health disparities exist.
- Promote education of health professionals about disparities in chronic disease incidence and care.

Strengthen infrastructure and data systems

- Use health IT (e.g., EHR and data management systems) to support the integration of clinical preventive services and community-based prevention strategies.
- Implement and test value-based payment models for the prevention, treatment, and management of chronic conditions.

Enable local innovations

- Encourage public health and primary care integration at the local level (e.g., community, hospital, HCBS providers, and schools) to tailor prevention initiatives to the needs and conditions of local populations.
- Identify ways to align state- and federal-level activities to support local integration of prevention efforts (e.g., CMS/CDC, CMS/ACL, etc.).
- Develop and test models that encourage and strengthen links among public health, clinical care, and community supports for health and wellness.

Foster learning organizations

- Support clinician and health worker education about multiple chronic conditions, population health, self-management tools, and strategies for coordination among clinical and community-based preventive services regarding available services and their effectiveness.
- Encourage multidisciplinary, cross-sector learning communities that bring together clinicians, licensed providers, patients and families; care partners; community health workers; urban planners; and other community stakeholders.

Goal 4: Promote effective prevention and treatment of chronic disease and conditions

Objectives	Desired Outcomes
Increase appropriate use of screening and prevention services	• Consumers understand and use their preventive benefits • Communities that promote health and wellness through prevention are created, sustained, and recognized • Prevention-focused health care and community efforts are available, integrated, and mutually reinforcing • Increased use of screening and preventive services that can reduce disparities • Increased rates of primary, secondary, and tertiary prevention
Strengthen interventions to prevent heart attacks and strokes	• Improved cardiovascular health through evidence-based community interventions • Expanded adoption of healthy lifestyle behaviors across the life span • Increased access to effective medical and other preventive services in clinical and community settings • Decreased rates of heart attacks and strokes • Eliminate disparities in rates of heart attacks and strokes
Improve quality of care for people with multiple chronic conditions	• Individuals are empowered to use self-care management • Providers are equipped with tools and information, to identify comorbidities and interventions that address MCC • Targeted research is focused on individuals with MCCs, and effective interventions are supported • Development of quality measures includes MCC management and care • Disparities in care are eliminated for people with MCC • Morbidity and mortality from MCCs are decreased

Objectives	Desired Outcomes
Improve behavioral health (BH) access and quality care	• More effective use of mental health and substance abuse screens to identify, refer, and treat individuals • Increased sharing of health IT data with BH providers by primary care providers • Increased use of health IT by BH providers to facilitate the sharing of information between BH providers and primary care providers • Individuals initially identified with a BH condition receive services within 30 days of screening / identification • Better availability of evidenced-based practices for individuals with BH conditions • Reduced admission to inpatient facilities and emergency rooms for people with BH conditions (regardless of reason for admission) • Improved access for older adults to depression and alcohol misuse treatment • Better quality of life for people with ADRD and their families
Improve perinatal outcomes	• Reduced elective deliveries prior to 39 weeks (by induction or cesarean section) • Improved appropriateness and timeliness of perinatal care for all pregnant women • Decreased premature births • Improved inter-conception care (care for women who had a previous pregnancy that ended in an adverse outcome, and who may have high-risk conditions and/or behaviors)

Goal 5: Work with communities to promote best practices of healthy living

Strategic Result: Best practices are promoted, disseminated, and used in communities.

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These include economic policies and systems, development agendas, social norms, social policies, and political systems.

Many factors influence health and well-being, including individual behavior, access to health services, and the environments where people live and work. For example, some environmental health hazards disproportionately affect low-income communities. Excess mold, allergens, and lead contamination are more often found in low-income housing. Perceptions of safety may impact the amount of time children and adults engage in physical activity outdoors. People with limited access to affordable, healthy foods, due to geography or transportation constraints are less likely to consume the recommended amounts of such foods from recommended food groups.

Efforts to improve lives through access to appropriate health care rely on deploying evidence-based interventions and strong partnerships among local health care providers, public health professionals, community and social service agencies, and individuals. Public health agencies, community planners, social service organizations, and HCBS providers play critical roles in addressing many of these issues at local, state, and tribal levels. Health care providers and systems can improve performance in this area through enhanced communication, increased knowledge, and streamlined payment systems.

CMS is committed to building and strengthening relationships with all partners to better link Medicare, Medicaid, and CHIP beneficiaries, and the providers that serve them, with communities and resources that support good health. In particular, CMS will encourage providers to partner with local and state public health improvement efforts so that Medicaid, Medicare, and CHIP beneficiaries can benefit from the high-quality community-based programs and services that support healthy living, such as exercise classes, self-management programs, health management support groups, lead abatement services, school-based health and fitness programs for youth, food assistance programs, farmers' markets, and tobacco cessation programs.

Some current federal efforts to promote healthy living and healthy communities include:

- Let's Move!
- Safe Routes to School National Partnership;
- CDC: Partnerships to Improve Community Health;
- CDC: Racial and Ethnic Approaches to Community Health;
- WIC Farmers' Market Nutrition Program/U.S. Department of Agriculture Senior Farmers' Market Nutrition Program;
- The Surgeon General's National Prevention Strategy;
- The Surgeon General's Call to Action to Promote Healthy Homes;
- The White House's Neighborhood Revitalization Initiative; and
- The Program for All-inclusive Care for the Elderly.

Goal 5 – Foundational Principles

Eliminate disparities

- Target environmental health initiatives, like lead abatement and asthma self-management programs, in lower-income and minority communities that are disproportionately exposed to hazardous chemicals and allergens.
- Evaluate effectiveness of initiatives aimed at addressing social determinants of health.
- Promote best practices that address social determinants of health.
- Promote education of health professionals regarding disparities in social determinants of health and environmental factors.

Strengthen infrastructure and data systems

- Develop systems to facilitate and sustain coordination among community and government agencies that can affect social determinants of health and environmental factors.
- Use health IT to support the integration of public health, primary care, and behavioral health care.

Enable local innovations

- Use the community health needs assessment (CHNA) process to engage partners across sectors to identify and prioritize community development opportunities to promote health and to spread best practices in the CHNA process.
- Develop Innovation Center model tests that enable local innovation in addressing the social determinants of health and improving health outcomes.
- Identify ways to leverage state and federal efforts to support local integration of resources that promote healthy communities (e.g., transportation, planning, recreation, education, and environment).

Foster learning organizations

- Support clinician and health worker education and workforce development related to population health and strategies for effective coordination among clinical and community preventive services.
- Encourage multidisciplinary, cross-sector learning communities that bring together clinicians licensed providers, persons and families; community health workers; urban planners; public health agencies; and community stakeholders.

Goal 5: Work with communities to promote best practices of healthy living

Objectives	Desired Outcomes
Partner with and support federal, state, and local public health improvement efforts	• Promote successful interoperability of health IT systems • Improve population health outcomes • Reduce disparities in health outcomes • Reduce health care costs through better coordination across health sectors
Improve access within communities to best practices of healthy living	• Children and adults have increased access to community-based preventive services • Evidence-based preventive services are widely shared and adopted by schools, families, and communities • Schools, families, and communities have the tools for promoting healthy living • Prevention-focused health care and community efforts are available, integrated, and mutually reinforcing
Promote evidence-based community interventions to prevent and treat chronic disease	• Promote effective diet, exercise, and other health behaviors that can ameliorate and control chronic diseases and behavioral health conditions
Increase use of community-based social services and HCBS	• People are routinely connected to relevant services offered by community organizations and other sources • Improved integration of health infrastructure, social services, and HCBS

Goal 6: Make care affordable

Strategic Result: Quality care is affordable for individuals, families, employers, and governments.

CMS is committed to better care, healthier people, and smarter spending. Although historically health care spending increased at a faster rate than the economy grew for decades, data since 2010 shows that the growth rate of health care spending has slowed to historic lows, thanks in part to health care reform efforts. Despite the decrease in the growth rate of spending, work remains to ensure access to high-quality, affordable care for consumers. Higher costs lead to underutilization of appropriate care and services, greater financial burden on the sickest and most vulnerable, and increased burden on providers and payers. CMS is the largest payer of health care in the United States, providing health coverage for more than 100 million individuals—about one in three Americans. As the largest payer, CMS has the ability to drive change in the health care system to reward high-value care.

Making sure the right care is delivered to the right person at the right time, every time, can also make care more affordable. Reducing costs goes hand-in-hand with the aims of expanding access, providing high-quality care, and promoting population health. Specifically, cost reduction may be achieved by:

- Reducing medical errors;
- Improving care coordination;
- Investing in health IT;
- Improving transparency of cost and quality data;
- Paying providers based on the quality and efficiency of care delivered;
- Developing and promulgating clinical and non-clinical guidelines and quality standards;
- Improving team management of complex patients with multiple comorbidities; and
- Increasing administrative efficiency.

CMS will foster these strategies for more affordable care by:

1. Establishing common measures that will help assess the cost impact of new programs and payment systems;
2. Improving data systems by encouraging and supporting Health Information Exchanges (HIE) that facilitate secure sharing of patient information;
3. Making utilization and cost of care data available to providers in a manner that is understandable and actionable;
4. Making health care costs and quality more transparent to consumers and providers, enabling them to make better choices and decisions;
5. Conducting the Quality Innovation Organization Learning and Action Network to change the way providers are paid, care is delivered, and information is distributed; and
6. Implementing national quality improvement programs and initiatives to systematically spread known best practices to reduce costs and improve care.

For example, the Medicare Shared Savings Program promotes the goal of reducing growth in expenditures for Medicare fee-for service beneficiaries. It encourages delivery of high-quality care through outcomes-based payment arrangements that link incentives to quality performance and total costs of care in Medicare Parts A and B. Other initiatives include the Hospital Value-Based Purchasing Program, which adjusts hospital payments made by Medicare for inpatient services based on hospitals' performance on measures that fall into a number of domains, including patient safety, clinical outcomes, and patient experience of care. The new MIPS and the transition of clinicians to Alternative Payment Models (APMs), as called for by the MACRA legislation, supports and reinforces the transformation of payment to clinicians based on value. CMS has also made data publicly available on the cost of services provided to Medicare beneficiaries by hospitals and physicians. Ultimately, CMS's goal is to link these cost data with provider performance on quality measures across settings of care.

Quality improvement initiatives that work in synergy with data transparency and payment incentives are also encouraging lower costs. According to the December 2014 report released by HHS, the "Interim Update on 2013 Hospital-Acquired Condition Rate,"$12 billion was saved as a result of a reduction in hospital-acquired conditions between 2010 and 2013.

CMS must also improve its ability to manage cost information internally to better identify key drivers of high costs and to look for outliers. CMS can use this information to identify opportunities to implement policies that drive down costs and support efforts to reduce fraud and abuse.

Goal 6 – Foundational Principles

Eliminate disparities

- Identify disparities in care through the stratification and analysis of claims data to recognize care patterns and gaps that do not adhere to established guidelines.

Strengthen infrastructure and data systems

- Ensure that standardized race, ethnicity, primary language, geographical (rural/urban), sexual orientation and gender identity (SOGI), and disability information is collected to identify disparities in health care delivery outcomes to the extent permitted by law.
- Implement and test value-based payment models that link payment incentives to measures of cost and quality.
- Support health IT adoption and health information exchanges to track patterns of care and individual outcomes across-settings, which can identify opportunities to reduce cost and improve quality.
- Provide more frequent feedback on quality and cost data to providers to promote understanding of care patterns and gaps and to identify opportunities for improvement and care redesign.
- Make cost and quality information easily understandable and publicly available for all provider types.

Enable local innovations

- Support the collection and interpretation of quality and cost data at the local level, which providers can use to target interventions for improving quality and reducing cost.
- Support local providers in developing innovative ways to make cost information transparent and understandable to consumers.

Foster learning organizations

- Support health worker education about reducing inappropriate and unnecessary care, starting with treatments and tests highlighted in the Choosing Wisely® campaign.
- Strengthen the availability and delivery of team-based primary care by supporting learning and action networks and other community forums that can disseminate best practices and spread knowledge from high performers.

Goal 6: Make care affordable

Objectives	Desired Outcomes
Develop and implement payment systems that reward value over volume	• Test new payment models to identify those that lead to improved health • New outcome and experience metrics are used for payment determinations • Outcomes-based payment arrangements link incentives to quality measures • Provider administrative burden is reduced • Access to quality primary and team-based care is expanded • Reduced cost and increased quality in all settings of care
Use cost analysis data to Inform payment policies	• Routinely review cost data by line of service and region to determine practice patterns and identify outliers • Improved analytic capacity to investigate cost drivers that inform payment model design and policies • Quality and cost data inform program integrity and fraud investigations via the Center for Program Integrity and other auditing and review capacities at CMS

Implementation and Evaluation

For CMS to manage its many health care quality improvement activities, respond quickly to new program priorities and requirements, and address an ever-growing workload with limited resources, we must excel at strategy management, strategic thinking, and action. This CMS Quality Strategy is designed as a tool to help CMS ensure that resources are directed toward agency priorities, operational risks are immediately identified, employees are held accountable for meeting the agency's quality goals and desired outcomes, and performance is effectively measured and reported. The strategy is a living document that evolves over time as initiatives are adjusted to meet the desired strategy outcomes and performance targets.

Implementation

In the early phases of implementation of the 2014 Quality Strategy, CMS recognized the need to expand its implementation approach to address the comprehensive nature of the strategy's initiatives, some of which are within CMS's purview, while others involve engaging and collaborating with stakeholders in different HHS components. This led to the development of Affinity Groups to expand membership of the objective-led subgroups to support the breadth of the CMS Quality Strategy implementation.

The CMS Quality Strategy Affinity Groups are cross-functional teams of program managers and stakeholders that collaborate to achieve the strategy goals. The role of the Affinity Groups is to generate results for the CMS Quality Strategy by identifying and aligning all CMS levers to drive improvement on specific quality strategy goals and objectives, strengthening relationships within CMS, and building advocacy across HHS agencies. For example, the Person and Family Engagement Affinity Group works to coordinate all activities such as quality improvement, quality measurement, and technical assistance across all settings of care and all CMS programs. The group identifies and aligns these activities intentionally around the objectives and foundational principles of the CMS Quality Strategy. The Quality Strategy Affinity Group is responsible for overseeing and coordinating the implementation of the CMS Quality Strategy.

Evaluation

CMS will continue to develop a comprehensive, agency-wide process to define, capture, and report short-term performance measures and long-term performance outcomes, as well as project milestones for CMS Quality Strategy goals. Evaluation of this Quality Strategy has two main components: First, we assess the extent to which the planned activities are implemented and the impact they have on the goals of the Quality Strategy; and second, we evaluate the impact and effectiveness of the quality improvement activities implemented throughout the national health care network. While the first component is primarily internal, the second relies on collaboration with many partners and stakeholders to develop, implement, and report performance data from a broad array of quality improvement activities across health care settings.

Reporting

The CMS Quality Strategy will be revisited and updated biennially. Goal-level performance targets will be evaluated at least annually, depending on the reporting schedules of their specific performance measures. To highlight our accomplishments and progress toward achieving CMS's strategic goals, the Quality Strategy Affinity Group reports progress to CMS leadership. All Affinity Groups address progress

on our performance compared to the strategic goals and identifies any mid-course strategy adjustments. The performance management framework aligns our progress on CMS's strategic goals and objectives to the performance commitments of the senior executives responsible for moving those priorities forward. In turn, these expectations are incorporated into the performance plans of managers and employees.

Consistent with the Government Performance and Results Modernization Act (GPRAMA) (P. L. 111-353), CMS has consistently used meaningful, outcome-oriented, public-facing performance measures that highlight fundamental program purposes and focus on our role as a steward of taxpayer dollars. We maintain our commitment to achieving performance outcomes by continuing to develop a comprehensive and integrated approach to performance management that directly supports this plan as well as the CMS Strategy and the National Quality Strategy.

Evaluation Methods

The evaluation of this ambitious quality improvement undertaking requires multiple methods of integrating quantitative and qualitative measures, process and outcome metrics, and innovative assessment strategies. The following subsections describe some of our current evaluation methods.

Data-driven Improvement

To meet the need for urgent improvement in the nation's health care system, CMS is conducting its quality work with a strong commitment to continuous review of data and rapid testing of new interventions. This includes a cross-program commitment to:

- Monitor one or two quantifiable, project-level goals with deadlines, preferably defined as outcomes, against which progress can be tracked regularly;
- Review and respond to data and new ideas; and
- Set up simple, interim measurement systems, based on self-reported data and sampling, that are sufficient for achieving improvement (and complement summative evaluation approaches).

Formative Evaluation

We conduct formative evaluation during and throughout a project to assess progress and to help agents and drivers identify ways to change activities to improve effectiveness. Formative evaluation questions include:

- What are the criteria for determining the effectiveness of goals and policies?
- What are the goals and objectives of the projects, and how well is CMS achieving them at this time?
- What will the agency do with the information gathered?
- What corrective actions, including terminating project activities, should be taken?
- To what extent does the progress align with the CMS Quality Strategy's Desired Outcomes?

We conduct summative evaluation annually to assess the impact of the Quality Strategy, and the extent to which we are realizing our goals and objectives. Summative evaluation questions include:

- What are the criteria for determining the effects of the Quality Strategy's goals and policies? To what extent have CMS's operational plans addressed the Quality Strategy?
- How can CMS use the data gathered from summative evaluation to inform the next cycle of strategic planning? How valid were CMS's assumptions over the course implementing the Quality Strategy? Do they still apply, and if not, why and how should they be revised?