# AGENCY-SPECIFIC PLAN FOR THE NATIONAL QUALITY STRATEGY

## Centers for Medicare & Medicaid Services (CMS)

| Program | Description | NQS Priorities* | | | | | | Current-Year Activities | Metrics | Future-Year Plans** | Vision/End Goals |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | | | | |
| Adult Medicaid Quality Grants Program | The Adult Medicaid Quality Grants Program is a 2-year funding opportunity designed to support grantee Medicaid agencies in using the initial core set of health care quality measures for adults enrolled in Medicaid and support quality improvement activities. | | | | | | ★ | • Support grantee Medicaid agencies in testing and evaluating methods for collection and reporting of the initial core set of health care quality measures across varying care delivery settings.<br>• Develop staff capacity to report, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid.<br>• Conduct at least two Medicaid quality improvement projects related to the initial core set of measures. | Grantee projects will aim to measure, monitor, and improve the quality of health care for adults enrolled in Medicaid using at least 15 of the 26 quality measures that comprise the initial core set of health care quality measures for adults enrolled in Medicaid. | • Collect, analyze, and make publicly available the measurement data reported by the States (P6, Goal 1). | • Support State Medicaid agencies in building capacity to collect, report, and analyze data on the initial core set of health care quality measures. |
| Advanced Primary Care Practice Demonstration (APCP) | This demonstration promotes accessible, continuous, and coordinated patient-centered care. It transforms Federally Qualified Health Centers (FQHC) into Patient-Centered Medical Homes (PCMHs) and evaluates the effects of the advanced primary care practice model on three areas: accessibility, quality, and cost of care for Medicare beneficiaries served by the FQHCs. This demonstration is also referred to as the PCMH Initiative. | | | | | | ★ | • Facilitate the transformation of FQHCs to PCMHs to enable the delivery of advanced primary care services including delivery change management, electronic health record (EHR) implementation, and coordination of preventive and acute services.<br>• Provide financial support to FQHCs applying for National Committee for Quality Assurance (NCQA) PCMH recognition.<br>• Improve patient-centered care coordination by integrating a team approach to health delivery through the inclusion of doctors, hospitals, and other health care providers.<br>• Periodically participate in site visits, focus groups, and interviews with FQHCs. | The health centers are evaluated by NCQA recognition levels. PCMH readiness scores are taken for all FQHCs at the time of application and every 6 months thereafter. Every 6 months, 10% of FQHCs are randomly selected for audit.<br>CMS periodically provides FQHCs with feedback reports including survey score changes, comparison of survey scores of other FQHCs, and quarterly claims-based cost and utilization data on Medicare beneficiaries. | • By FY 2014, 25% of health centers achieve NCQA Level 3 recognition (P6, Goal 1). | • By the end of the demonstration, 90% of participating FQHCs achieve NCQA Level 3 PCMH recognition. |

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| Bundled Payments for Care Improvement (BPCI) | BPCI links payments for the multiple services patients receive during an episode of care to improve care coordination and quality. This combination of payments creates a greater incentive to decrease unnecessary duplication of services, reduce preventable medical errors, increase patient safety, and lower costs. | | | ✓ | | | ★ | • Support BPCI participants in implementing the following three types of bundled payment models:<br>– Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care<br>– Model 3: Retrospective Post-Acute Care Only<br>– Model 4: Acute Care Hospital Stay Only<br>• The models use either retrospective payment bundling, in which CMS and providers set a target payment amount for a defined episode of care, or prospective payment bundling in which CMS makes a single, prospectively determined bundled payment.<br>• Provide assistance to providers in order to select health conditions to bundle, develop the health care delivery structure, and determine how payments will be allocated among participating providers.<br>• Conduct Webinars and learning sessions to share findings on the private sector's involvement with episode-based payments and care redesign. | BPCI compares the total payment amount of a defined episode of care with the target price set by CMS and providers. CMS monitors clinical quality, patient experience, and outcomes of care.<br>Models 2–4 use a standardized set of measures established by CMS. Additional measures for all models can be proposed by applicants. (Model 1 implementation is currently suspended and under review.) | • Further coordination among health care providers through the bundling of payments for single episodes of care (P3, Goal 1).<br>• Improve care transitions to decrease number of readmissions and lower health care costs (P6, Goal 1). | • Replace fragmented care with coordinated care among doctors, hospitals, and other health care providers.<br>• Lower health care costs through improved care coordination. |
| CHIPRA Quality Demonstrations | Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Demonstrations are a 5-year grant program with cumulative grant awards totaling $100 million. Eighteen States across 10 grants participate in multicomponent projects aimed at improving health care quality and delivery systems for children enrolled in the Medicaid and the Children's Health Insurance Program (CHIP). | | | | | | ★ | • Experiment with and evaluate the use of the initial core set of children's health care quality measures for Medicaid and CHIP.<br>• Promote the use of health information technology in the delivery of care for children.<br>• Implement provider-based models that improve the delivery of Medicaid/CHIP children's health care services.<br>• Demonstrate the impact of the model children's electronic health record format (two grantees are participating in this activity). | Each demonstration has identified its own set of measureable objectives and outcomes. | • Continue to identify best practices for improving children's health care (P6, Goal 1). | • Improve children's health care quality through the use of health quality measures, health information technology, and provider-based delivery models. |

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| Community-based Care Transitions Program (CCTP) | This program is part of Partnerships for Patients. CCTP tests models for improving care transitions from the hospital to other settings and for reducing readmissions for high-risk Medicare beneficiaries.<br><br>Community-based organizations (CBOs) will be paid for care transition services. | | | ★ | | | ✓ | • Select and award 2-year agreements to pay CBOs an all-inclusive rate per eligible discharge based on the cost of care-transition services provided at the patient level and implementation of hospital-level systemic changes.<br>• Provide funding for testing models that improve care transitions by targeting specific populations and providing strategies for identifying high-risk patients. | CMS evaluates and tracks each CBO's targeted performance thresholds on quality and utilization measures such as 30-day all-cause readmission rates, 90- and 180-day readmission rates, mortality rates, observation services, and emergency department visits. | • Provide assistance to CBOs to incorporate care-transition interventions and services to address readmissions (P3, Goal 1).<br>• Aid CBOs in improving provider communications and patient engagement (P3, Goal 1).<br>• Document measurable savings to the Medicare program from CCTP (P6, Goal 1). | • Preserve or enhance quality of care for Medicare beneficiaries while providing care-transition interventions across settings.<br>• Help achieve Partnership for Patient goals: (1) reduce preventable errors in hospitals by 40%, and (2) reduce hospital readmissions by 20%. |
| Comprehensive Primary Care Initiative (CPCI) | This multipayer 4-year initiative fosters collaboration between public and private health care payers to strengthen primary care through the testing of health care payment and delivery models. This program provides participating practices with resources to (1) manage care for patients with high health care needs, (2) ensure access to care, (3) deliver preventive care, (4) engage patients and caregivers, and (5) coordinate care across the medical neighborhood. | ✓ | ✓ | ✓ | | | ★ | • Provide support for 500 primary care practices to test payment and delivery models.<br>• Convene CMS and participating payers to share utilization and cost data with providers.<br>• Coordinate with commercial and State health insurance plans to offer additional non-visit payment to primary care doctors and nurses to better coordinate care for their patients.<br>• Promote a market-based community through three annual meetings, monthly Web-based meetings, and dissemination of materials.<br>• Share best practices for health and health care quality improvements at the local, State, and Federal levels. | CPCI measures program implementation through nine primary care practice milestones determined by CMS for the first year, including risk status, access to medical records, and meeting attendance. Due to the diversity of practice sites, the specific metrics are decided by each practice to illustrate care improvement. | • Help patients create a plan of care incorporating individual health risks, circumstances, and values (P2, Goal 2).<br>• Improve the value proposition of primary care to lower health system costs (P6, Goal 1).<br>• Provide market-based learning opportunities to share best practices (P3, Goal 3).<br>• Include practices in Shared Savings program in years 2–4 (P6, Goal 1). | • Establish a new national model to coordinate care, improve health, and lower costs for all Americans.<br>• Invest in primary care practices throughout communities to help small businesses, patients, and taxpayers use their health care dollars more wisely. |

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| Hospital Value-Based Purchasing (HVBP) Program | The HVBP Program implements a pay-for-performance approach to health care payment by rewarding hospitals for the quality of care they provide to Medicare patients, rather than the quantity of procedures they perform. This program attempts to transform the quality of hospital care by realigning hospitals' financial incentives. | | | | | | ★ | • Conduct national provider calls and Webinars for hospitals and other stakeholders to discuss summaries of activity, developments in the program, and provide previews of the program's future plans.<br>• Encourage care quality improvement and use of best clinical practices through restructured incentives. | Hospitals receive incentive payments based on their performance across 12 clinical process-of-care measures and 8 patient experience-of-care measures or on the improvement of their performance relative to a baseline performance. | • In FY 2014, incentives will expand performance measurement to include an additional clinical process of care measure and three outcome measures (P6, Goal 1). | • Transform health care in hospitals by improving patients' experience of care and following best clinical practices. |

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| Medicare and Medicaid Electronic Health Records (EHR) Incentive Program | This program provides incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) as they meet a set of criteria for the use of Certified EHR technology within the Medicare and Medicaid programs. Certified EHRs should be used (1) in a meaningful manner, (2) for electronic exchange of health information to improve quality of health care, and (3) to submit clinical quality measures (CQMs) and other such measures selected by the Secretary. CMS implements this program through the constructs of meaningful use and clinical quality measurement. | ✓ | ✓ | ★ | ✓ | | | • Support providers in reporting clinical quality measures, overall health IT transition, and the implementation of Certified EHR technology.<br>• Capture electronic health information in a standardized format and use it to track key clinical conditions, enable clinical decision support, facilitate electronic health information exchange in care coordination processes, and engage patients and their families in their care.<br>• Provide patients with timely electronic access to their health information. | In 2013, EPs must report on six total clinical quality measures. Eligible hospitals and CAHs must report on all 15 clinical quality measures.<br>In 2013, EPs are required to meet 15 core objectives ranging from E-Prescribing (eRx) to clinical summaries of patients' office visits. They are also required to report on 5 out of the 10 menu objectives which range from summary of care record for transitions of care to reminders for patients' preventive/ followup care, including one public health-related objective.<br>In 2013, eligible hospitals and CAHs are required to meet 14 core meaningful use objectives and 5 out of the 10 menu objectives. | • Implement more rigorous health information exchanges (HIEs) to increase patient access to comprehensive data (P3, Goal 1).<br>• Increase electronic transmission of patient care summaries across multiple settings (P3, Goal 1).<br>• Require providers to be responsible for promoting patient engagement with online health information (5% of patients must access their health information) (P3, Goal 3).<br>• Align clinical quality measures across quality reporting programs to reduce the burden on providers and emphasize NQS priorities (P3, Goal 1).<br>• Utilize clinical quality measure data to inform policy decisions, clinical processes, and clinical decision support to continuously improve the quality of care (P3, Goal 1). | • Promote the spread of EHRs to improve health care and reduce costs.<br>• Use EHRs to increase patient access to self-management tools.<br>• Use EHRs to achieve the NQS quality improvement goals and priorities. |

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| Medicare Shared Savings Program | The Medicare Shared Savings program provides incentives for better coordination and cooperation among providers and with their patients to improve beneficiary outcomes and increase value of health care by (1) promoting accountability for the care of Medicare fee-for-service (FFS) beneficiaries, (2) requiring coordinated care for all services provided under Medicare FFS, and (3) encouraging investment in infrastructure and redesigned care processes. Participating providers receive a portion of the savings if they successfully achieve quality standards and lower growth in health care costs. | ✓ | ✓ | ✓ | | | ★ | • Currently oversee the 114 Accountable Care Organizations (ACOs) participants in the Medicare Shared Savings Program and 32 additional ACO participants in the Pioneer ACO initiative.<br>• Enact annual application process to bring additional ACOs online in January each year.<br>• Provide support to ACOs in identifying gaps in care and opportunities for better coordination and quality improvement, and redesigning care processes through feedback reports and claims data.<br>• Assist ACOs with understanding program requirements and achieving program goals and objectives through the sharing of information and other learning activities. | ACOs are evaluated on 33 quality measures in 4 domains of patient/ caregiver experience: preventive health, care coordination/ patient safety, and at-risk populations, as established by CMS. | • Phase in pay-for-performance measures as organizations complete their second and third years of program participation (P6, Goal 1).<br>• Track quality and cost metrics reported by participants to monitor and improve performance (P3, Goal 3).<br>• Promote patient engagement by sharing health care expertise and increasing the beneficiary's role in shared decisionmaking (P2, Goal 2).<br>• Reduce unnecessary health care costs through increased care coordination (P1, Goal 3). | • Improve the quality of care for Medicare FFS beneficiaries through accountability and redesigned infrastructure and care processes.<br>• Increase patient engagement to make informed health care decisions.<br>• Promote coordination and information among health care providers. |

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| Million Hearts™ Initiative | Million Hearts is a national HHS initiative, co-led by CMS and CDC and executed by Federal, State, and private sector partners, that coordinates cardiovascular disease prevention and treatment activities across the public and private sectors. | | | ✓ | ★ | ✓ | ✓ | • Conduct educational campaigns to increase awareness about heart disease prevention and empower patients to take control of their heart health.<br>• Participate in community efforts to promote smoke-free air policies and reduce sodium in the food supply.<br>• Use health information technology and quality improvement initiatives to standardize and improve the delivery of care for high blood pressure and high cholesterol.<br>• Scale-up proven clinical and community strategies across the nation that address major risk factors for cardiovascular disease, including appropriate Aspirin use for those at risk, Blood pressure control, Cholesterol management, and Smoking cessation (the ABCS of cardiovascular disease). | This initiative will track the number of heart attacks and strokes each year in the United States. The initiative will also track key measures related to the ABCS of cardiovascular disease (e.g., smoking prevalence, trans fat consumption, aspirin use). The National Committee for Quality Assurance will also align cardiovascular Healthcare Effectiveness Data and Information Set (HEDIS) measures to the Million Hearts campaign. | • Prevent 1 million heart attacks and strokes by 2017 (P4, Goal 3).<br>• Achieve 65% adherence to proven prevention techniques—aspirin use, blood pressure control, and treatment for high cholesterol (P4, Goal 2).<br>• Reduce smoking prevalence from 19% to 17% of the population (P5, Goal 2).<br>• Decrease sodium intake by 20% and trans fat consumption by 50% of the population (P5, Goal 2). | • Empower Americans to make healthy choices.<br>• Improve care for people at risk by focusing on the ABCS of cardiovascular disease such as better blood pressure control and smoking cessation. |
| Partnership for Patients | This public-private partnership promotes patient safety and quality by aiming to (1) keep patients from getting injured or sicker, and (2) help patients heal without complication. This initiative strives to reduce preventable hospital-acquired conditions and 30-day hospital readmissions. | ★ | | ✓ | | | ✓ | • Assist 26 Hospital Engagement Networks with conducting training programs for hospitals to increase patient safety, providing technical assistance to hospitals to achieve quality measurement goals, and implementing a tracking system to monitor hospital progress on quality improvement goals.<br>• Provide educational resources on how health care providers can make care safer and improve care coordination. | This partnership tracks patient safety and quality through the following measures: hospital readmission rates, adverse drug events (ADE), catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism (VTE), ventilator-associated pneumonia (VAP), and other hospital-acquired conditions. | • Further collaboration among health care providers to reduce complications in care transitions (P3, Goal 1).<br>• Increase the number of community-based organizations (CBOs) to partner with acute-care hospitals and provide care transition services (P1, Goal 1).<br>• Continue to identify all-cause harms and develop effective strategies for preventing them in the future (P1, Goal 2). | • Reduce preventable hospital-acquired conditions 40% by 2013.<br>• Decrease 30-day hospital readmissions 20% by 2013. |

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| Physician Quality Reporting System (PQRS) | PQRS promotes the reporting of quality measure data through the use of incentive payments and payment adjustments for participating providers who satisfactorily report on quality measures data for covered professional services for Part B Medicare beneficiaries. This program helps with the implementation of the goals of value-based purchasing. | | ✓ | ★ | | | | • Collaborate with participants on program and data collection requirements.<br>• Align participation and reporting criteria with other quality reporting programs within CMS.<br>• Conduct monthly national calls with providers to discuss the program and other relevant updates, providing time for questions and answers.<br>• Provide incentive payment of 0.5% of eligible professional's total estimated Medicare Part B Physician Fee Schedule (PFS) to those who successfully report PQRS measures. | For 2012, 143 individual quality measures and 12 measure groups were eligible for claims-based reporting. Reporting mechanisms include claims, qualified registry, qualified Electronic Health Record (EHR), and Group Practice Reporting Option (GPRO) Web interface. Measure specifications can vary by year.<br>Starting in 2015, PQRS will no longer use an incentive structure. Medicare Part B PFS payment adjustments will decrease by 1.5% for nonparticipants based on the 2013 reporting year. | • Increase the number of PQRS participants to expand the quality measure data collecting and reporting (P3, Goal 1).<br>• Continue alignment efforts with other CMS quality reporting programs to reduce administrative burden and increase participation in quality reporting (P3, Goal 1). | • Advance data collection and reporting of quality information.<br>• Reduce administrative burden of reporting with other quality reporting programs wherever possible. |

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# Appendix A. National Quality Strategy Priorities and Long-Term Goals

| # | Priority | Long-Term Goals (Recommended by the National Priorities Partnership) |
|---|---|---|
| 1 | Making care safer by reducing harm caused in the delivery of care. | 1. Reduce preventable hospital admissions and readmissions.<br>2. Reduce the incidence of adverse health care-associated conditions.<br>3. Reduce harm from inappropriate or unnecessary care. |
| 2 | Ensuring that each person and family are engaged as partners in their care. | 1. Improve patient, family, and caregiver experience of care related to quality, safety, and access across settings.<br>2. In partnership with patients, families, and caregivers—and using a shared decisionmaking process—develop culturally sensitive and understandable care plans.<br>3. Enable patients and their families and caregivers to navigate, coordinate, and manage their care appropriately and effectively. |
| 3 | Promoting effective communication and coordination of care. | 1. Improve the quality of care transitions and communications across care settings.<br>2. Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.<br>3. Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities. |
| 4 | Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease. | 1. Promote cardiovascular health through community interventions that result in improvement of social, economic, and environmental factors.<br>2. Promote cardiovascular health through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.<br>3. Promote cardiovascular health through receipt of effective clinical preventive services across the lifespan in clinical and community settings. |
| 5 | Working with communities to promote wide use of best practices to enable healthy living. | 1. Promote healthy living and well-being through community interventions that result in improvement of social, economic, and environmental factors.<br>2. Promote healthy living and well-being through interventions that result in adoption of the most important healthy lifestyle behaviors across the lifespan.<br>3. Promote healthy living and well-being through receipt of effective clinical preventive services across the lifespan in clinical and community settings. |
| 6 | Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. | 1. Ensure affordable and accessible high-quality health care for people, families, employers, and governments.<br>2. Support and enable communities to ensure accessible, high-quality care while reducing waste and fraud. |