

Quality in Motion



Acting on the CMS
National Quality Strategy
April 2024



Quality in Motion: Acting on the CMS National Quality Strategy



Executive Summary

In 2022, the Centers for Medicare & Medicaid Services (CMS) launched the CMS [National Quality Strategy](#) (NQS), a plan aimed at improving the quality and safety of health care for everyone, with a special focus on people from underserved and under-resourced communities. The CMS NQS builds on CMS' efforts to improve health care quality for individuals across their lifespan and continuum of care by using all the Agency's levers, including value-based payment programs and models; health and safety standards (including conditions for coverage and conditions of participation); survey and certification programs; quality measurement and public reporting; and quality improvement technical assistance.

Quality Mission:

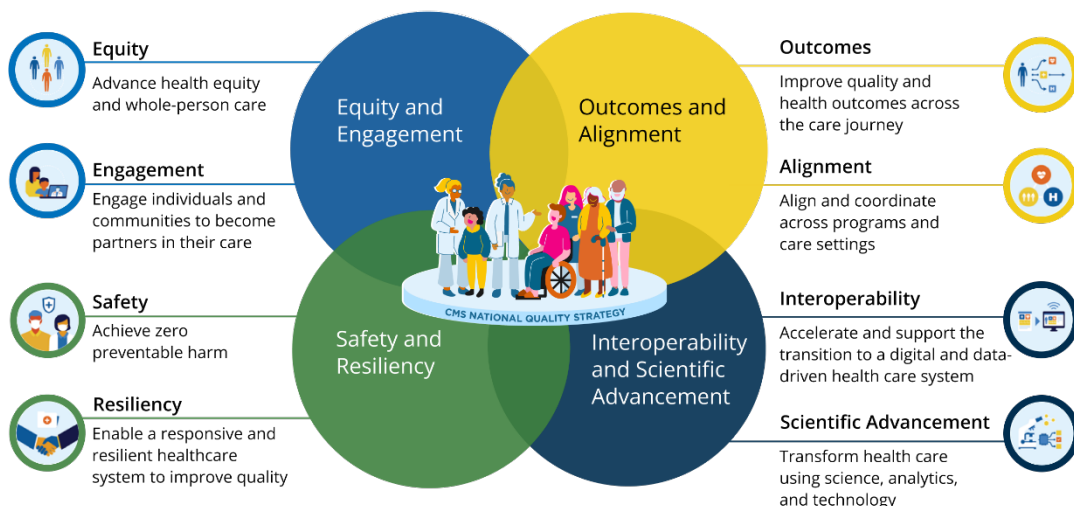
To achieve optimal health and well-being for all individuals.

Quality Vision:

CMS, a trusted partner, is shaping a resilient, high-value American health care system that delivers high-quality, safe, and equitable care for all.

The CMS National Quality Strategy has four priority areas, each with two goals. This action plan provides details on how CMS is putting these eight goals into action.

CMS National Quality Strategy Goals



Priority Area: Outcomes and Alignment

Outcomes: Improve Quality and Health Outcomes Across the Care Journey



Key Actions to Improve Health Outcomes and Health Care Quality:

- **Drive improvements on high-priority outcomes.** CMS operates quality reporting and value-based payment programs and alternative payment models to promote accountability through payment and public reporting for safe, high-quality care for all. These programs, along with the [Quality Improvement Organization \(QIO\) Program](#), catalyze quality efforts on the most pressing health topics, such as behavioral health, maternal health, long-term services and supports (LTSS), and oral health.
- **Leverage quality measures to improve health outcomes.** Quality measures are a key tool for CMS to identify opportunities for improvement and evaluate progress. CMS is shaping a measure ecosystem that focuses on improving outcomes, driving value-based care, and reducing provider reporting burden.
- **Set benchmarks to track progress.** Clear targets and increased reporting transparency help CMS advance improvement efforts around a shared objective. CMS conducts a [triennial assessment](#) of quality measures used across its programs to monitor clinical improvements and track progress on narrowing disparities.

Alignment: Align and Coordinate Across Programs and Care Settings



Key Actions to Increase Alignment Across Quality Efforts:

- **Develop aligned approaches across quality programs.** When more providers focus on the same quality priorities and have similar measurement approaches, the Agency can improve coordination and comparisons across programs and across the continuum of care. Alignment also builds the evidence base for quality interventions and assists in identifying disparities in care.
- **Align quality measures through the Universal Foundation.** Alignment through the [Universal Foundation](#) focuses the attention of health care providers and systems on important clinical areas and support services. CMS released the initial adult and pediatric measure sets and is collaborating across the Agency to identify “add-on” measure sets for specific populations or settings of care.

- **Streamline measure development and selection.** Addressing alignment early in the measure lifecycle improves efficiency and increases the adoption of aligned measures into programs. CMS is increasing its internal coordination on measure development and implementation activities to achieve a more parsimonious measure portfolio, simplify compliance with reporting requirements, and reduce provider reporting burden.
- **Collaborate across the nation for greater impact.** Achieving optimal health for all individuals requires active partnership across the health care ecosystem. CMS actively collaborates with partners and other payers to advance quality through measurement and other levers.

Priority Area: Equity and Engagement

Equity: Advance Health Equity and Whole-Person Care



Key Actions to Advance Equity in Health Care Quality and Outcomes:

- **Incorporate equity into the design of all quality programs and policies.** To maximize impact, equity must be woven into all aspects of program and policy design from the start. CMS is developing strategies and resources to guide policy and program design toward improving the quality of care for people who are at higher risk for poor health outcomes and to ensure providers have the resources to address their needs.
- **Use effective incentives to advance equity within CMS programs.** Quality incentive and value-based programs reward providers who deliver excellent care to underserved populations by linking payment to performance on quality measures. CMS also tests innovative payment models that incorporate incentives to encourage and sustain participation of safety net providers to assess novel ways of delivering high-quality and cost-efficient care.
- **Improve health equity data collection, standardization, and analysis.** CMS is strengthening data collection and analysis of race and ethnicity data as well as standardized data elements on social determinants of health (SDOH). With improved health equity data, CMS can better understand existing disparities and how policy changes can improve health equity.

Engagement: Engage Individuals and Communities to Become Partners in Their Care



Key Actions to Ensure Engagement to Improve Health Care Quality:

- **Incorporate individual and community input into strategy and policy.** CMS ensures it hears the voices of the individuals and communities it serves through listening sessions, advisory committees, and expert panels and considers their perspective in shaping program policies and participation requirements.
- **Expand use of person-reported outcomes and experience measures.** CMS is moving toward a more person-centered approach to evaluating quality that incorporates the experiences of individuals, families, and caregivers. CMS is committed to developing and implementing more person-reported outcome measures and experience of care surveys across quality programs and innovation models.
- **Give individuals access to their own health data and meaningful information.** CMS is working to ensure individuals have access to their own medical records and health data. Access to one's personal health data makes individuals, families, and caregivers more effective partners in their care.
- **Provide a platform for public reporting.** Public reporting of quality and safety measures promotes transparency. CMS provides several tools to empower individuals, families, and caregivers to use this available information to make meaningful decisions about their care.

Priority Area: Safety & Resiliency

Safety: Achieve Zero Preventable Harm



Key Actions to Drive Improvements in Safety and Reduce High-Priority Harms:

- **Expand transparency to increase accountability for safety.** Public reporting on quality and safety empowers individuals to make decisions about where to go for care and encourages providers to improve care by understanding their performance in comparison to others. CMS recognizes that individuals, families, and caregivers are critical partners in their care and that expanding their access to information is a key step toward improved safety.

- **Drive improvements in safety through meaningful incentives, quality initiatives, and regulatory oversight.** Safety events are rarely the result of individual error, but rather they reflect system-level flaws. CMS continues to support efforts to promote a holistic safety culture. CMS leverages meaningful incentives, technical support through QIOs, and health and safety standards to reduce harm and achieve safety goals.
- **Promote safety initiatives that protect the health care workforce.** CMS provides oversight and technical assistance interventions to ensure that health care workers have a safe working environment.
- **Improve safe use and security of electronic health records (EHRs) and personal data.** The safe and efficient use of EHRs can facilitate safety by ensuring that providers have the most complete data at the point of care. CMS continues to focus on the advancement and safe use of EHRs through technology requirements and incentive programs.

Resiliency: Enable a Responsive and Resilient Health Care System to Improve Quality



Key Actions to Support Health Care System Resiliency:

- **Build resiliency by addressing staffing and infrastructure needs.** CMS leverages payment and incentive policies as well as technical assistance to strengthen the health care workforce and ensure adequate resources to deliver needed care.
- **Support emergency response activities to enable providers to continue providing high-quality care through times of crisis.** Public health emergencies (PHEs) and disasters can lead to unprecedented quality and safety concerns. CMS partners with states, communities, and providers and can provide flexibility in program requirements to ensure sufficient health care services are available during emergencies.
- **Address population and health care system needs during climate events.** PHEs caused by extreme weather events include extreme heat, floods, storms, and poor air quality days, which create additional demand for health services and stress infrastructure. CMS safety and oversight regulations allow for innovation to address emissions reduction, increase operations sustainability, and improve infrastructure resiliency and other climate adaption and resilience goals, while program flexibility can address health needs caused and exacerbated by the effects of climate change.

Priority Area: Interoperability and Scientific Achievement

Interoperability: Accelerate and Support the Transition to a Digital and Data-Driven Health Care System



Key Actions to Promote Interoperability for Quality Efforts:

- **Champion the standards and technology needed for interoperability.** Standardized and interoperable data aid in the exchange of health information to support care and improve quality. CMS partners with other federal agencies and partner organizations to develop and improve standards that leverage existing architecture to enable flexible and automated data exchange throughout the health care ecosystem.
- **Transition to digital quality measurement to advance interoperability.** Moving toward digital quality measurement can reduce data collection and reporting burden, while increasing the use of available data to inform treatment and help prevent medical and other errors. CMS supports this transition through incentives and program requirements to promote interoperability.
- **Promote organizational shifts and collaboration for interoperability readiness.** CMS commits to partnering with providers, communities, partner organizations, and federal agencies to create a health care system that leverages the vast amount of information gathered across the care journey.

Scientific Advancement: Transform Health Care Using Science, Analytics, and Technology



Key Actions to Drive Progress on Scientific Advancement:

- **Streamline the coverage review process for promising new technologies.** Strategically streamlining the coverage review process supports access to promising new medical technologies while ensuring safeguards for those who use them. CMS is taking additional steps to increase transparency and clarify the requirements for generating and evaluating evidence.
- **Improve data available for research and evidence-based practice.** CMS maintains and shares extensive data with the public and researchers. Initiatives to improve high-quality data collection and sharing will promote transparency and generate insights into evidence-based practices.

- **Advance predictive analytics and tools, such as artificial intelligence (AI), that may inform health care decisions.** AI and other predictive analytic methods have the potential to generate cost savings and produce better health outcomes. CMS continually uses, evaluates, and enhances analytical methods and models that support clinical care and quality efforts.



Through the CMS [National Quality Strategy](#), CMS strives to improve health care quality across the nation. To advance the NQS goals, CMS welcomes collaboration from government partners, health care payers and providers, and community-based organizations, as well as all individuals, families, caregivers, and communities. In this “Call to Action,” CMS invites all partners to:

- **Prioritize the use of Universal Foundation measures.**
- **Commit to improving health care safety and reducing harm.**
- **Advance health equity to improve health outcomes and eliminate disparities.**

Together, CMS and its partners across the health ecosystem are putting **quality in motion** to achieve the mission of optimal safety, equity, health, and well-being for all individuals.

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Introduction



As a trusted partner and the nation's largest single payer for health care, the Centers for Medicare & Medicaid Services (CMS) commits to ensuring the highest quality care and best health outcomes for all individuals. In 2022, CMS launched the CMS [National Quality Strategy \(NQS\)](#), a cross-cutting initiative to advance the Agency's strategic vision. The CMS NQS builds on CMS' efforts to improve health care quality for individuals across their lifespan and continuum of care to work toward a more equitable, safer, and outcomes-based health care system.

CMS plays a critical role in promoting health care quality by using all the Agency's levers, including quality programs, payment policies, health and safety standards (including conditions for coverage and conditions of participation), regulations, and oversight. The CMS NQS guides the Agency's efforts to deliver a resilient and high-value health care system. Quality is essential to value—the highest quality care at the most affordable cost. By emphasizing quality across CMS programs, the Agency advances high-value care.

Quality Mission:

To achieve optimal health and well-being for all individuals.

Quality Vision:

CMS, a trusted partner, is shaping a resilient, high-value American health care system that delivers high-quality, safe, and equitable care for all.

To achieve the quality mission and vision, the CMS National Quality Strategy adopts eight goals organized in four priority areas.

The **Outcomes and Alignment** priority area ensures coordination in identifying high-priority outcomes across the Agency and in implementing quality reporting and value-based programs and policies that address these priorities.

The **Equity and Engagement** priority area advances health equity and ensures the voices of individuals, families, and caregivers are valued and directly contribute to how CMS evaluates the impact of its programs on equity, safety, and quality.

The **Safety and Resiliency** priority area advances CMS' renewed commitment to enabling a deeply embedded safety culture and ensuring the health care ecosystem has tools and solutions for achieving safer routine care while maintaining high safety levels in times of crisis.

The **Interoperability and Scientific Advancement** priority area recognizes that improved data practices support advanced analytics, rapid-cycle feedback, and aligned quality measurement strategies that can lead to continuous improvement in person-centered care.

Improving health care quality and safety requires a multifaceted approach. Through putting quality in motion, CMS emphasizes connections across the NQS goal areas, CMS' key actions to advance each goal, and collaborative efforts to align high-quality health care with key partners.





OUTCOMES

Improve Quality and Health Outcomes Across the Care Journey

Objective: Improve quality in high-priority clinical areas and support services.

As the nation's largest payer for health care, CMS is committed to ensuring the highest quality care and best health outcomes for all individuals in their journey across the continuum of care. Each individual's care may involve different care settings, whether home- or community-based, hospital, or post-acute care (PAC), as well as different payer types, such as Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP), and Marketplace plans.

The Outcomes goal of the CMS National Quality Strategy focuses on improving quality and health outcomes for high-priority clinical areas and support services across the Agency. CMS uses many levers to deliver high-quality, person-centered care across its policies and programs. The Agency evolves those programs to achieve clinical targets on quality measures and improve specific health outcomes through coordinated efforts across CMS informed by the CMS National Quality Strategy. The [Universal Foundation](#), an aligned set of high-priority measures, is a vital step toward achieving the Outcomes goal as discussed in more detail in the Alignment goal section.

CMS supports the Agency's commitment to providing value through the highest quality care at the most affordable cost, for the system and for individuals. Critical elements of quality encompass safety, person-centered care, integration of physical and behavioral health, and equity. CMS' value-based programs link payment to quality performance and reward health care providers with incentive payments for providing high-quality care. Ensuring these programs use the most impactful quality measures and evidence-based quality improvement interventions is effective at improving health outcomes while accelerating the adoption of value-based care.

Key Actions to Improve Health Outcomes and Health Care Quality

- Drive improvements on high-priority outcomes.
- Leverage quality measures to improve health outcomes.
- Set benchmarks to track progress.

CMS operates close to 30 quality reporting and value-based payment programs to promote accountability for safe, high-quality care for all people through payment incentives and public reporting. These programs measure quality at the level of individual clinicians, groups of clinicians, health care settings, health insurers, states, and value-based entities, such as accountable care organizations (ACOs). CMS is committed to increasing the number of Medicare and Medicaid beneficiaries who are in care relationships with providers accountable for both

cost and quality such as ACOs. CMS is also committed to increasing the enrollment of dually eligible individuals in integrated care models to improve care coordination and deliver better outcomes. To support this effort, the [CMS Innovation Center](#) is testing innovative payment and service delivery models that improve the quality of care, care coordination, and health outcomes.

Drive improvements on high-priority outcomes.

CMS aims to improve clinical and health outcomes while reducing the reporting burden on clinicians and providers. CMS supports quality efforts on high-priority clinical areas, many of which align with the [CMS Cross-Cutting Initiatives](#), to address the most pressing health topics, such as behavioral health, maternal health, long-term care (LTC), and oral health. These efforts emphasize the Agency's levers of measurement, payment, regulatory oversight, and technical assistance to enhance quality and health outcomes.

To address [behavioral health](#), for example, the [QIO Program's draft 13th Statement of Work](#) (SoW) includes behavioral health as one of its four priority areas. This will allow QIOs to provide focused, hands-on technical assistance on data-driven quality improvement interventions for providers with limited resources and those providing care to communities that are underserved. The [CMS Innovation Center](#) is launching the [Innovation in Behavioral Health model](#) to advance integrated physical and mental health care and promote better coordination and outcomes for Medicare and Medicaid beneficiaries. Additionally, the Universal Foundation includes behavioral health measures in both the adult and pediatric measure sets. CMS also issued [guidance](#) to nursing home surveyors to appropriately address residents' behavioral health needs.

High-Priority Clinical Areas

To drive improvements in health outcomes, CMS focuses national efforts on high-priority clinical areas, which align with the [Cross-Cutting Initiatives](#) of the CMS Strategic Plan and broader Department of Health and Human Services (HHS) goals. CMS is working to set clinical outcomes goals for the following high-priority clinical areas to track progress toward achieving the goals of the CMS National Quality Strategy:

- Maternity care
- Safety
- Cancer prevention, screening, and treatment
- Kidney care and organ transplantation
- Preventive services, including immunization
- Diabetes
- Sickle cell anemia
- Behavioral health care, including substance use disorders, mental health, and pain care
- Age-friendly health (i.e., older adult care and services)
- Oral health
- HIV and Hepatitis C

Outcome Goal Connections

The eight goals of the CMS NQS are highly interconnected. The current work in the Outcomes goal area has impacts across all eight goals, but it is particularly relevant to explore:

- *How **Equity** Affects Outcomes:* Every person should be able to achieve their highest level of health and well-being. To accomplish this, CMS recognizes the importance of setting clinical outcomes that prioritize equity across and within populations and increase transparency in public reporting of health equity outcomes data.
- *How **Safety** Affects Outcomes:* CMS is committed to setting clinical and individual outcomes that promote safety for individuals served by CMS as a priority of the CMS National Quality Strategy. Identifying high-priority, preventable harms can produce more useful outcomes benchmarks.
- *How **Alignment** Affects Outcomes:* Improving quality outcomes will include working across the Agency and with other partners throughout the nation. The CMS National Quality Strategy aligns, where possible, with the work in other high-impact areas, such as CMS Cross-Cutting Initiatives, and across the federal government.

CMS also launched the [Maternal and Infant Health Initiative](#), which works directly with states to improve maternal health outcomes. CMS organized the [Improving Postpartum Care Learning Collaborative](#) to support state Medicaid & CHIP agencies' efforts to improve health outcomes among postpartum people. The [Transforming Maternal Health model](#) will support Medicaid agencies in multiple states to build alternative payment models to improve maternal outcomes. The Agency has published quality improvement resources, such as [the toolkit on Increasing Access, Quality, and Equity in Postpartum Care in Medicaid & CHIP](#).

CMS quality initiatives contribute to progress on the [President and First Lady's Cancer Moonshot](#), a national effort with a bold goal to prevent more than four million cancer deaths by 2047. The Universal Foundation includes important cancer screening measures to support cancer detection and treatment. The [CMS Innovation Center](#) is testing the [Enhancing Oncology Model](#) to improve care coordination, quality, and health outcomes for patients, while holding oncology practices accountable for the total cost of care. CMS also finalized in the [Physician Fee Schedule](#) Medicare coding and payment for care navigation for high-risk conditions such as cancer. The Merit-based Incentive Payment System (MIPS) offers the [Advancing Cancer Care MIPS Value Pathway \(MVP\)](#) which includes a subset of measures and activities to offer a more meaningful and connected assessment of the quality of cancer care. In addition to the [Prospective Payment Systems \(PPS\)-Exempt Cancer Hospital Quality Reporting Program](#) that focuses on a subset of dedicated cancer centers, CMS seeks opportunities to ensure high-quality cancer care for patients wherever they are treated. CMS has also issued [guidance and quality improvement resources](#) to support Medicaid & CHIP state programs to help more people access evidence-based tobacco cessation services and succeed in their efforts to quit tobacco.

Leverage quality measures to improve health outcomes.

Quality measurement is a central lever of the CMS National Quality Strategy. The [Meaningful Measures Initiative](#) supports the CMS NQS by moving the ecosystem of [measures](#) toward outcomes and driving value-based care. Throughout the process of measure development, selection, and implementation, CMS promotes measures that focus on key quality areas that safeguard health, identify significant opportunities for improvement, are scientifically valid and reliable, and are aligned across quality programs to develop systematic improvements for the health care system. Publicly reported measure results ensure that: providers, facilities, and payers receive feedback on their performance; the public can compare reported results; and CMS can hold these entities accountable for their performance.

CMS continues to increase the number of outcome measures, including person-reported outcome measures, across its portfolio. According to the [2024 National Impact Assessment of CMS Quality Measures](#) report, 41 percent of measures used in quality programs in 2023 were outcome measures, compared to 36 percent in 2016. Although structural and process measures can provide important information about care systems and processes, outcome measures reflect the impact of the service or intervention on improving health status. Outcome measures often reveal the most valuable information to improve clinical outcomes, recognize and track disparities, and ensure the delivery of high-value care. Public reporting of measure results on the [Care Compare](#) websites and in CMS rating systems also promotes transparency of information about quality care and is a vital aid for individuals, families, and caregivers.

Set benchmarks to track progress.

Quality measurement and quality improvement work together to address national health care priorities. Benchmarking is a tool to compare results and identify best practices in care. The [2024 National Impact Assessment of CMS Quality Measures](#) report found that 88 percent of measures used across CMS quality programs had improved or maintained performance between 2016 and 2019. Improvements were notable in several areas, including fewer all-cause readmissions for Medicare Advantage patients and stable hospital-wide all-cause readmission rates for traditional Medicare patients; improved or stable blood pressure control for patients assigned to ACOs and MIPS clinicians; and increased or stable screening rates for colorectal and breast cancer in patients assigned to ACOs and MIPS clinicians. Screening for depression increased for patients assigned to ACOs and was stable for patients assigned to MIPS clinicians, while medication adherence for individuals newly diagnosed with major depression improved among Medicare Advantage enrollees and remained stable for Marketplace members.

However, the report also identifies opportunities for improvement. The COVID-19 PHE created challenges for most health systems and limited their ability to sustain improvement; of measures with sufficient data, 38 percent in 2020 and 47 percent in 2021 had worse than expected performance. Additionally, while there were a few notable improvements, measures with stratified results show persistent disparities among racial and ethnic groups and for individuals with dual eligibility.

As mentioned above, in 2023 nearly half of CMS measures were outcome measures, reflecting the Agency's focus on measuring and improving health outcomes for those served by CMS programs. The [QIO Program](#) also uses value-based quality measures for benchmarking and to focus the QIOs on quality improvement initiatives that align with the measures and priorities of CMS quality programs and initiatives. The [QIO Program's draft 13th SoW](#) draws on the Universal Foundation for measures to ensure that CMS' measurement and improvement efforts mutually reinforce and maximize the desired impact on outcomes.

Spotlight on Action

- The [CMS Innovation Center strategy](#) includes five objectives for system transformation in testing and tools to improve care: driving accountable care, advancing health equity, supporting care innovations, improving access by addressing affordability, and partnering to achieve system transformation. Several new models implement these objectives to improve high-priority health outcomes. For example, the [Making Care Primary model](#) works to strengthen primary care across the country, especially in federally qualified health centers and practices new to value-based care, because access to high-quality primary care is associated with better health outcomes and equity for all people and communities. The [Guiding an Improved Dementia Experience \(GUIDE\) Model](#) supports people living with dementia and their unpaid caregivers through a comprehensive package of care coordination and care management, caregiver education and support, and respite services.
- The [QIO Program](#) is one of the largest federal programs focused on improving the quality of services for Medicare beneficiaries. Future work streams for the [QIO Program](#) include emphasis on prevention and chronic disease management, patient safety, behavioral health, and care coordination. The program has a specific aim to help providers with limited quality improvement resources deliver quality services to underserved populations.
- [End Stage Renal Disease \(ESRD\) Network Organizations](#) are a crucial part of improving and coordinating kidney care and organ transplantation. CMS relies on ESRD Network Organizations to develop relationships with dialysis professionals, providers, and patients and to create a collaborative environment to improve patient care. A primary function of the ESRD Network is to assist CMS in understanding the needs of ESRD patients by including patients in quality improvement activities that focus on improving cost-effectiveness, ensuring high quality of care, encouraging kidney transplantation and home dialysis, and assisting patients to return to work and maintain quality of life.



ALIGNMENT

Align and Coordinate Across Programs and Care Settings

Objective: Increase alignment by focusing provider and health care system attention on high-priority clinical areas and support services.

For over 20 years, the quality movement has achieved improvements in quality performance and accountability. At the same time, however, the proliferation of quality reporting and incentive initiatives—and their respective program requirements and quality measures—has created confusion, increased reporting burden, and introduced variations in clinical decision making for common health conditions.

The Alignment goal of the CMS National Quality Strategy aims to increase alignment and coordination across the quality ecosystem by focusing attention on high-priority clinical areas and support services. Greater alignment across measure sets, quality program policies and requirements, and quality improvement initiatives can ensure that all parts of the health care system work together toward common goals and priorities to achieve better health outcomes for all individuals served by CMS.

The CMS National Quality Strategy builds on previous efforts to improve quality and is integrated with broader CMS and HHS strategic goals and initiatives. By ensuring alignment across these efforts, CMS sends a uniform and cohesive message about its priorities.

Key Actions to Increase Alignment Across Quality Efforts

- Develop aligned approaches across quality programs.
- Align quality measures through the Universal Foundation.
- Streamline measure development and selection.
- Collaborate across the nation for greater impact.

Develop aligned approaches across quality programs.

Quality improvement efforts address complex problems that may have multiple points of failure as the root causes. When more providers focus on the same quality priorities across care settings, health insurers, and value-based entities, it is easier to build the evidence base for quality interventions, draw comparisons across programs, and identify disparities in care. For example, the [QIO Program](#) works with providers to implement evidenced-based quality interventions and measure improved outcomes across four priority areas: prevention and chronic disease management, patient safety, behavioral health, and care coordination. QIOs provide hands-on technical support to ensure providers are on a trajectory toward meeting target improvements in health outcomes for underserved communities. QIOs also use a

Alignment Goal Connections

- *How **Equity** Affects Alignment:* Better demographic data collection, stratification, and reporting across health care will help improve equity. Alignment across quality programs and innovation models on approaches will promote better identification and tracking of disparities in care.
- *How **Safety** Affects Alignment:* Aligning safety priorities across HHS agencies strengthens efforts to ensure patient safety and reduce harm.
- *How **Outcomes** Affect Alignment:* Aligning quality measurement and improvement activities increases attention on high-priority conditions, which can lead to improvements in clinical outcomes, better recognition and tracking of disparities, and delivery of high-value care.

standardized set of outcome measures to evaluate if their technical support for providers leads to improvement in care delivery and health outcomes for Medicare patients across settings.

CMS implements an aligned approach across its quality and value-based programs to incentivize excellent care for people who are underserved. This approach, called [Rewarding Excellence for Underserved Populations \(REUP\)](#), provides substantial incentives for the type of care transformation that improves quality care for underserved populations.

CMS is implementing the REUP approach through health equity adjustments and possible bonus points in the scoring methodology for some programs, such as the Medicare Shared Savings Program, Medicare Advantage and Part D Star Ratings System, and the Hospital Value-Based Purchasing and the Skilled Nursing Facility (SNF) Value-Based Purchasing programs. CMS continues to explore additional quality programs and settings where application of the REUP principles may be appropriate to advance this concerted effort to provide higher quality care to underserved populations.

Align quality measures through the Universal Foundation.

Balancing the need to measure all important aspects of quality with the need to reduce measure proliferation, CMS applies a building-block approach. The Agency starts with a [Universal Foundation](#) of quality measures that apply across as many CMS quality and value-based care programs as possible, and adds specific measures or sets when needed for specific populations or settings.

The initial adult and pediatric measures in the Universal Foundation increase alignment by focusing provider and health care system attention on a streamlined collection of quality measures that address high-priority clinical areas and support services in the measurement domains of wellness and prevention, chronic conditions, behavioral health, care coordination, person-centered care, and equity.

CMS collaborates across the Agency to identify “add-on” measure sets to support consistent assessment of care provided to specific populations or in certain settings. For example, as part of CMS’ [cross-cutting initiative on maternity care](#), CMS works to address opportunities to improve maternal health outcomes and reduce disparities. By building a maternal health “add-on” measure set, CMS can optimize quality measures that support high-quality care across the care continuum and those facilities and clinicians delivering maternity care. Future add-on measure sets may focus on hospital care, PAC and LTC, and home- and community-based services (HCBS).

Streamline measure development and selection.

CMS is committed to aligning other aspects of its quality programs for increased efficiency, such as processes for developing and adopting quality measures. A more streamlined, parsimonious measure set across programs also reduces provider reporting burden and simplifies compliance with reporting program requirements. Increased coordination will prevent duplication of effort and decrease measure proliferation by addressing the needs of various programs, and the measurement considerations for specific populations and settings, earlier in the process.

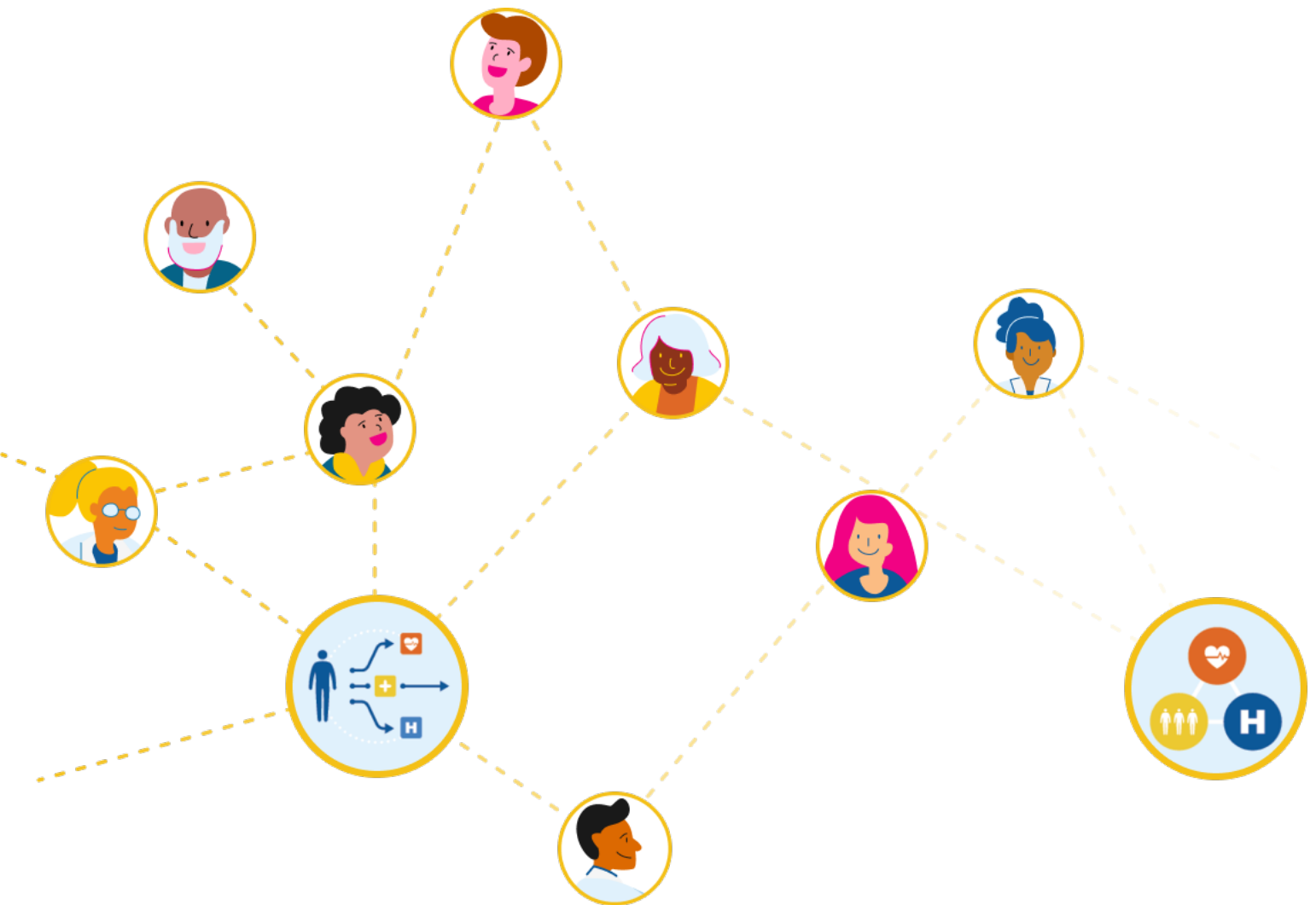
In addition, CMS increases alignment and collaboration by strengthening Agency-wide input into the annual process for identifying candidate measures for its Medicare quality programs. This process culminates in creating a Measures Under Consideration (MUC) List. Once the MUC List is finalized, a consensus-based entity, currently the [Partnership for Quality Measurement \(PQM\)](#), offers a process for meaningful partner engagement and public input into the pre-rulemaking measure review process. Increasing alignment across programs is a criterion considered in both the [Pre-Rulemaking Measure Review and Measure Set Review processes](#) coordinated by PQM. CMS then considers this feedback in developing its proposals issued through the federal rulemaking process.

Collaborate across the nation for greater impact.

CMS actively collaborates with federal partners and other interested parties on quality measurement and other levers to advance quality. Each federal agency has a distinct role in the quality enterprise, and aligning across agencies amplifies impact by prioritizing and focusing on similar goals and objectives. For example, CMS is an active partner in the [National Action Alliance to Advance Patient Safety](#), a public-private collaboration to improve both patient and workforce safety. CMS continues to engage in efforts that support broader alignment of quality efforts, for instance as part of the [Core Quality Measures Collaborative](#) and the [Health Care Payment Learning and Action Network](#).

Spotlight on Action

- CMS monitors and participates in multi-agency and public-private partnerships and collaborations to improve health quality throughout the nation, such as the National Action Alliance to Advance Patient Safety. This work seeks to achieve zero harm in health care. More information on the Action Alliance is available at: [The National Action Alliance To Advance Patient Safety | Agency for Healthcare Research and Quality \(ahrq.gov\)](https://www.aHRQ.gov)
- The Universal Foundation will evolve to best serve high-priority areas. The latest information on the Universal Foundation is available at: [Aligning Quality Measures Across CMS - the Universal Foundation | CMS](https://www.cms.gov)





EQUITY

Advance Health Equity and Whole-Person Care

Objective: Reduce health disparities and promote equitable care for all by using standardized methods for collecting, reporting, and analyzing health equity data across CMS quality and value-based programs.

CMS believes that every person should be able to achieve their highest level of health and well-being regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, dual eligibility status, or other factors that affect health care quality and health outcomes. Many individuals, families, caregivers, and communities, however, experience disparities in health outcomes and in the quality of care they receive. Granular, informative data are not always available to understand the underlying barriers to delivering equitable, high-quality care, which may limit the effectiveness of strategies and interventions in closing health equity gaps.

As the first pillar of the [CMS Strategic Plan](#), CMS views health equity as a cornerstone across CMS programs and policies. Each CMS Center and Office builds health equity into its work and has established health equity goals to improve the health care experience and outcomes of all individuals and communities served by CMS programs. CMS quality programs advance health equity by identifying measurable interventions to close gaps in quality care and outcomes.

The Equity goal of the CMS National Quality Strategy aims to reduce health disparities by promoting standardized data collection, reporting, and analysis across CMS programs. Better data are critical to understand the underlying root causes of disparities. This data can further inform the design, implementation, and operationalization of policies and programs that support health for all people served by CMS programs.

Key Actions to Advance Equity in Health Care Quality and Outcomes

- Incorporate equity into the design of all quality programs and policies.
- Use effective incentives to advance equity within CMS programs.
- Improve health equity data collection, standardization, and analysis.

Incorporate equity into the design of quality programs and policies.

The [CMS Office of Minority Health \(CMS OMH\)](#) spearheads efforts across the Agency to advance health equity through several strategies, including the [CMS Framework for Health Equity, The Path Forward: Improving Data to Advance Health Equity Solutions](#), and the [CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#). These strategies outline CMS' commitment to promoting health equity and identifying specific actions CMS can take to improve health outcomes and health care quality for underserved communities.

CMS also provides resources for implementing these strategies to providers, community organizations, and other partners. This includes [providing customized Health Equity Technical Assistance resources](#) to health care organizations for taking action to eliminate health disparities, such as best practices for measuring and reporting disparities to inform quality improvement activities.

Building on CMS' strategic priorities, the [CMS Innovation Center](#) is developing health care payment and service delivery models that address health disparities. These models, such as the ACO Realizing Equity, Access, and Community Health (REACH) Model and the Enhancing Oncology Model, are testing the impact of requiring model participants to have plans to identify and address health disparities, providing additional resources for safety net providers, and enhancing health equity data collection. By incorporating health equity priorities into the design of new models, CMS will have better access to data and a better understanding of the methodologies needed to evaluate equity and quality. This will inform efforts to improve quality and close disparities across CMS programs.

CMS also works to improve the quality of care for people enrolled in CMS programs who are known to be at higher risk for poor health outcomes, including people dually eligible for both Medicare and Medicaid. As an example, CMS aligns measure collection via Medicaid and Medicare programs to improve quality data collection and reporting for individuals who are dually eligible. In Medicaid & CHIP programs, CMS is advancing health equity through the use of quality reporting, care delivery transformation, and coverage of clinically appropriate, evidence-based services that support health-related social needs (HRSN). [Mandatory state reporting of Medicaid & CHIP Core Sets of quality measures](#), stratified by demographic factors, will help to identify health inequities and opportunities for continuous quality improvement.

CMS also supports state efforts to address [HRSN](#), such as food and housing insecurity, using innovative approaches to Medicaid ["in lieu of services"](#) options and section 1115 demonstrations. In Medicare, the Physician Fee Schedule services now include care involving [community health workers](#) who link underserved communities with critical health care and social services in the community, improving health outcomes for individuals with Medicare. Based on the successful [CMS Innovation Center](#) ACO Investment Model, CMS introduced [Advance Investment Payments in the Medicare Shared Savings Program](#) to encourage providers in rural and underserved areas to join ACOs. Participants can use these payments to invest in providing accountable care for underserved beneficiaries, increased staffing, and health care infrastructure, as well as to address HRSN. In addition, the [QIO Program's](#) American Indian and Alaska Native (AI/AN) Healthcare Quality Initiative provides quality improvement technical assistance and resources to health care providers who serve AI/AN populations to better address the health care inequities affecting these communities.

CMS emphasized the importance of health equity throughout the development of the [Universal Foundation](#). These foundational measure sets prioritize safe and equitable care for all individuals while applying to as many quality and value-based care programs as possible. One specific aim of the measure set is to identify disparities in care. CMS promotes this aim by selecting measures that are appropriate for stratification to recognize and track disparities among and within populations. The Adult Universal Foundation set includes an equity-focused measurement domain that includes measures that screen for SDOH. These SDOH screening measures are included in quality reporting programs for several settings and clinicians. Further analysis of the full set of Universal Foundation measures and the improved health equity data provided will inform the development of future equity efforts.

CMS developed an approach to promote equity in quality and value-based programs while avoiding identified pitfalls of other approaches. [Rewarding Excellence for Underserved Populations](#) (REUP) offers an upside-only monetary award that incentivizes excellent care without lowering standards for individuals who currently have limited access to high-quality health care services. CMS implements REUP in an aligned way across applicable programs, using REUP as a complementary approach to other CMS payment policies.

Equity Goal Connections

- *How **Interoperability** Affects Equity:* Interoperable data systems and processes can facilitate the standardized collection and reporting of health equity data. Moreover, data opportunities enhanced by interoperability practices, such as data completeness and data timeliness, help CMS use health equity data to evaluate and promote equitable care.
- *How **Outcomes** Affect Equity:* Identifying and understanding disparities and their drivers within prioritized health outcomes will help CMS better direct resources to address the underlying root causes. CMS can apply the investments in stratified reporting by demographic and SDOH factors to better inform policymaking.
- *How **Alignment** Affects Equity:* CMS acknowledges that health equity extends across work done within the Agency and by other federal partners. The equity goal is deeply ingrained with work supported by cross-cutting initiatives throughout CMS, such as [Maternity Care](#) and [Rural Health](#). The [CMS Framework for Health Equity 2022–2032](#) is consistent with the [Department of Health and Human Services' Health People 2030 Framework](#) and [Executive Order 13985](#) and [Executive Order 14091](#) on Advancing, and Further Advancing, Racial Equity and Support for Underserved Communities through the Federal Government.
- *How **Engagement** Affects Equity:* Ensuring that the voices of individuals are incorporated into policy decisions and that individuals have access to culturally and linguistically appropriate services (CLAS) can improve the health care experience and outcomes of individuals and communities served by CMS programs.

Use effective incentives to advance equity within CMS programs.

CMS' value-based quality programs reward providers that deliver high-quality care by linking payment to performance on quality measures. The [CMS Innovation Center](#) is incorporating incentives to encourage and sustain participation of underserved beneficiaries and safety net providers in its models. For example, models such as the [ACO REACH](#) model and the [Making Care Primary \(MCP\)](#) model adjust payments by clinical indicators and social risk, and hospitals participating in the [States Advancing All-Payer Health Equity Approaches and Development \(AHEAD\)](#) model will be eligible to earn a bonus for improved performance on disparity-focused measures. CMS continuously monitors and evaluates its quality programs to ensure the measures address challenges to health equity and the measure data can be used to identify disparities. To assist in these efforts, CMS provides [confidential feedback reports](#) to hospital and PAC providers that provide stratified results on select measures by race and ethnicity and by dual Medicare-Medicaid enrollment.

Several quality programs contain health equity-related measures, including screening for HRSN and hospital or facility commitment to health equity. The Star Ratings program established a [Health Equity Index](#) reward to incentivize Medicare Advantage and Part D plans to provide excellent care for populations that are underserved. Both the Hospital Value-Based Purchasing (VBP) and the SNF VBP programs include a health equity adjustment in the scoring methodology that incorporates incentives for the proportion of dually eligible patients treated, which is aligned with the health equity adjustment in the Medicare Shared Savings Program. As part of the [Quality Improvement Strategy \(QIS\)](#), qualified health plan issuers participating in a Marketplace for two or more consecutive years are required to report on the topic of reducing health and health care disparities in their QIS submission.

Improve health equity data collection, standardization, and analysis.

CMS strengthens the use of data and analytics across the Agency through its efforts to improve the collection of race and ethnicity data and standardized data elements on SDOH in CMS programs. For example, traditional Medicare and Medicare Advantage plans collect self-reported SDOH metrics via several means, including patient assessment instruments, surveys like the Medicare Current Beneficiary Survey and Consumer Assessment of Healthcare Providers and Systems surveys (CAHPS[®], a registered trademark of the Agency for Healthcare Research and Quality). CMS collects metrics for substance use, mobility data elements, and SDOH metrics for individuals experiencing end-stage renal disease, and all new [CMS Innovation Center](#) models incorporate requirements for self-reported demographic data and HRSN data. CMS also partners with the Office of the National Coordinator for Health IT (ONC) to implement new standards for collection and electronic exchange of structured health equity data through the [United States Core Data for Interoperability \(USCDI\)](#) SDOH data elements.

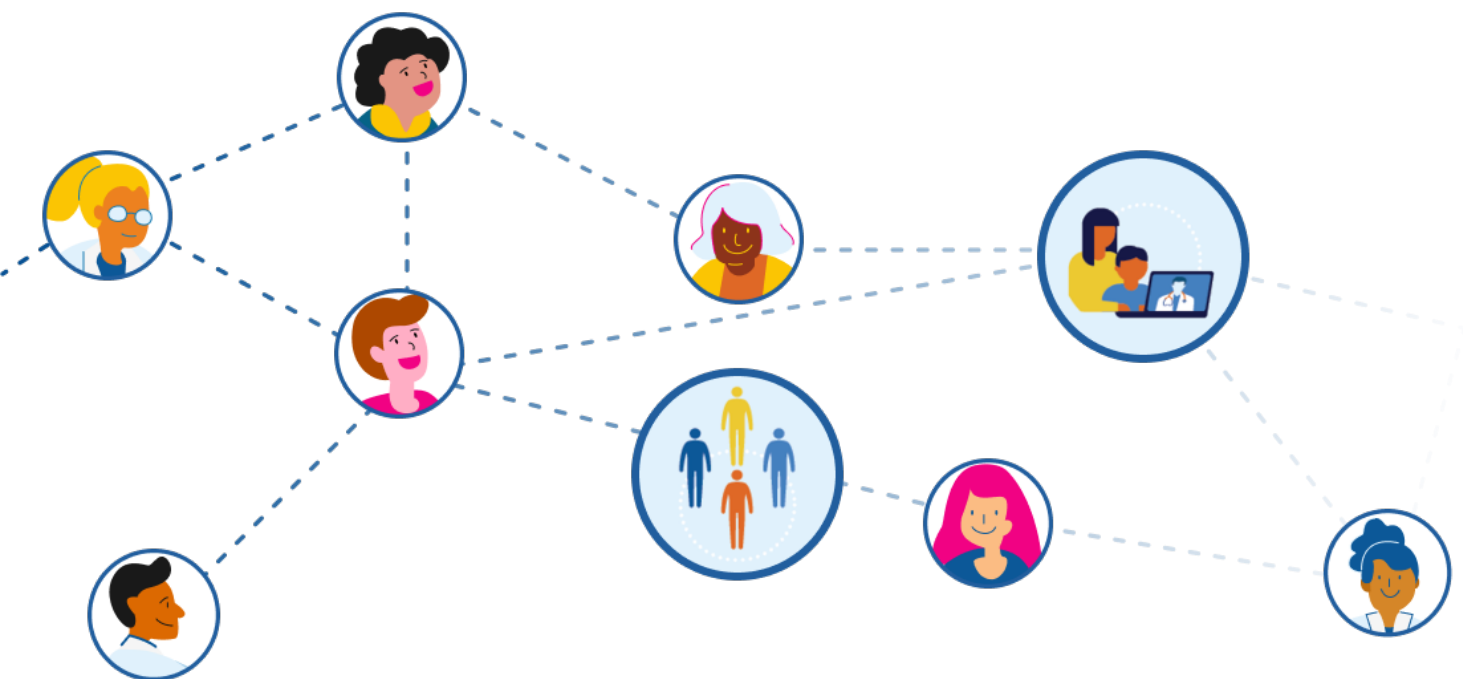
CMS dedicates significant resources to improving demographic data collection and investing in evidence-based methods for combining self-reported race and ethnicity data with survey and other administrative data sources. Through partnerships with state Medicaid programs, for example, CMS used these techniques to enable the first-ever national estimates of demographic characteristics of individuals served by the Medicaid & CHIP programs. These data were stratified by demographic subgroups and published in a series of [data briefs](#) to provide insight into how to serve this diverse population more equitably. CMS is also working to fill gaps in health equity data by providing access to disaggregated data through the [Mapping Medicare Disparities tool, an interactive data visualization tool](#), and [data “snapshot” reports](#) that include results stratified by sex, race, ethnicity, Medicare Advantage enrollment, dual eligibility/low-income subsidy, and rural-urban disparities.

One of the new indicators of individuals who may be underserved is the presence of SDOH-related diagnosis codes—SDOH Z codes—that indicate the individual’s care team has identified social risk factors or unmet needs. To encourage wider use of SDOH Z codes, CMS developed [resources](#) for community partners on how to collect and use SDOH Z codes to improve equity in health care delivery, research, and quality improvement initiatives. Through the [finalization of coding and payment](#), CMS now includes separate payments for services involving community health workers, care navigators, and peer support specialists. This will help the collection of SDOH data and facilitate connection to services based on identified needs. For example, care navigation codes also require care teams to designate when unmet SDOH needs affect the diagnosis and treatment of medical problems by using a corresponding SDOH Z code in the medical record.

With access to better data, CMS is expanding its impact analysis of payment policies on health equity by exploring differences in estimated average payments to hospitals based on characteristics of the patient populations they serve. The Agency [increased the payment severity designation](#) for hospital claims with specific SDOH Z codes for homelessness, recognizing that hospitals treating individuals experiencing homelessness often use more resources for treatment and discharge planning. CMS finalized this payment adjustment based on claims data analysis and plans to continue its analysis of the effects of SDOH on severity of illness, complexity of services, and consumption of resources.

Spotlight on Action

- The [HRSN framework](#) provides a guide to allowable services under Medicaid section 1115 demonstrations and other Medicaid & CHIP authorities. CMS encourages states to help individuals access coverage and care by addressing unmet HRSNs through coverage of clinically appropriate and evidence-based services, care delivery transformations, fiscal policy, and other related requirements.
- The [Universal Foundation](#) of quality measures acknowledges the importance of stratification and evaluation of measures to promote equitable care for all individuals. The adult measure set contains an Equity-focused measure domain with SDOH screening measures, which have been implemented in quality programs across several care settings.
- CMS published [The Path Forward: Improving Data to Advance Health Equity Solutions](#), which specifically describes CMS' approach to promote health equity for people enrolled in CMS programs, mitigate health disparities, and prioritize the Agency's commitment to expanding the collection, reporting, and analysis of standardized data for health equity. [Health equity technical assistance](#) resources are available to help health care organizations act on health disparities. The link offers resources covering grant research programs, data, Z Codes, trainings, and advancing equity.
- CMS released the [Sickle Cell Disease Action Plan](#) to improve the access, quality, and experience of health care for individuals living with Sickle Cell Disease (SCD). CMS supported the development of two pediatric SCD quality measures through the Medicaid & CHIP Pediatric Quality Measures Program to inform quality efforts and help identify health disparities. CMS also plans to conduct listening sessions to learn from key partners about the gaps in quality related to SCD and identify opportunities to improve overall health care quality for this population.





ENGAGEMENT

Engage Individuals and Communities to Become Partners in Their Care

Objective: Ensure individuals and caregivers have the information needed to make the best choices for their health, as well as a direct, significant, and equitable contribution to how CMS evaluates quality and safety.

Authentically engaging individuals, families, caregivers, and communities as active partners in their care ensures that the health care systems that serve them are respectful of and responsive to their preferences, needs, and values. This partnership is essential to person-centered care and to improve health care quality, safety, and equity. The Engagement goal of the CMS National Quality Strategy focuses on two components of engagement. The first is ensuring that individuals and caregivers have information to make the best choices for their health. The second is ensuring the voices of individuals are valued and that they directly contribute to how CMS evaluates the impact of its programs on quality, safety, and equity.

Key strategies for promoting the delivery of person-centered care include collecting experience measures and person-reported outcomes (PRO) and PRO-based performance measures (PRO-PM). Experience of care measures can assess a wide range of interactions that individuals have with the health care system and the aspects of those interactions that they value, such as timely appointments, easy access to information, and good communication with health care providers. A PRO is any report of an individual's health condition or health behavior that comes directly from the individual (or proxy when appropriate), without interpretation of the individual's response by a clinician. A PRO-PM captures person-reported outcome data on meaningful outcome metrics and incentivizes collaboration and shared responsibility for improving patients' health along the full spectrum of care. Self-reported data are a rich source for measuring outcomes such as health-related quality of life, symptoms and symptom burden, and health behaviors.

Together, experience surveys, PROs, and PRO-PMs provide the individual's perspective of their own health, their experience of the treatment or service, and the outcomes that are most important to them. Providers can use this data to assess the person-centeredness of the care they deliver and inform their treatment plans, and CMS can use PRO and PRO-PM data to incentivize providers to deliver high-quality care.

Key Actions to Ensure Engagement to Improve Health Care Quality

- Incorporate individual and community input into strategy and policy.
- Expand use of person-reported outcomes and experience measures.
- Give individuals access to their own health data and meaningful information.
- Provide a platform for public reporting.

Engagement Goal Connections

- *How **Safety** Affects Engagement:* Integrating engagement and safety through standards and best practices and ensuring that care is understandable are important aspects to improve care safety. For example, the National CLAS Standards can shape both safety and engagement practices. These standards can help ensure that individuals, families, and caregivers understand the relevant information about their care and services in a way that is linguistically accessible and culturally appropriate, and that can help to build the safety culture needed in the health system.
- *How **Interoperability** Affects Engagement:* Interoperability helps to promote the transfer of data across systems. Advancements in interoperability can give individuals and their families and caregivers access to meaningful care information in a timely manner to inform decisions about their care. This information can increase the engagement of those receiving care for shared decision making and improved health outcomes.
- *How **Outcomes** Affect Engagement:* Publicly reported data on care delivery, such as provider performance data shared in accessible formats and at appropriate literacy levels, can help engage individuals and promote more informed care choices. Promoting the availability of relevant data is an important aspect of the Outcomes goal of the CMS NQS and can continue to shape how individuals evaluate their care choices.

Incorporate individual and community input into strategy and policy.

To overcome biases in the health care system leading to health disparities, CMS is committed to hearing the voices of all those the Agency serves and reflecting their needs and preferences in program policies and participation requirements. CMS hosts listening sessions for those receiving care and their caregivers that cover policies and program changes, and CMS works with partners, such as patient and other advocacy groups and technical assistance providers, to ensure people from diverse backgrounds are included in health care decision making.

For example, nursing homes can actively engage residents, families, and caregivers in quality activities, such as identifying, addressing, and improving safety concerns. These [Resident and Family Advisory Councils](#) provide a forum for nursing home staff to meet with and receive suggestions from residents and their families and caregivers.

Federal rules require Medicaid managed care plans that cover Medicaid long-term services and supports (LTSS), Programs of All-Inclusive Care for the Elderly (PACE), and dual eligible special needs plans (D-SNP) to maintain [enrollee or participant advisory committees](#) that are consulted on various issues, including ways to improve health equity.

While developing the framework for the [Medicaid & CHIP Quality Rating System](#), CMS used multiple venues to get feedback from interested parties. This

included listening sessions and interviews with beneficiaries, caregivers, states, health plans, and external quality review organizations.

Individuals, families, and caregivers are also encouraged to participate on [CMS Technical Expert Panels](#), where they can share their personal experiences and feedback to shape quality project decisions, such as measure development work, and in the [PQM](#) process to review quality and efficiency measures under consideration for use by HHS. CMS is also exploring more user-friendly ways to collect individual perspectives on policy and strategy initiatives through interviews and surveys, such as designing surveys that are accessible on laptops and phones. CMS seeks to have a comprehensive process to engage with the public through diverse channels, including focusing on the human-centered design process where CMS works directly with clinicians, patients, third-party vendors, federal partners, and CMS components to collaboratively understand the context of the work and engagement.

Expand use of person-reported outcomes and experience measures.

CMS is committed to developing and implementing more person-reported experience and outcome measures across its quality programs to ensure the voices of individuals are included and incorporated into safety and quality efforts. CMS adopted the Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient Reported Outcome performance measure in the Hospital Inpatient Quality Reporting (IQR) program, the first PRO-PM measure introduced in IQR. Many CMS quality programs use experience surveys and are moving toward ensuring language accessibility.

Introduced in 2022, the [HCBS Quality Measure Set](#) includes several CAHPS survey measures, drives improvement in quality of care and outcomes for people receiving HCBS, and supports states' efforts to promote equity in their HCBS programs. Capturing experience of care is especially important for HCBS because each person's care goals are highly individualized. CMS also developed resources and provides technical assistance for states implementing the measure set.

All new [CMS Innovation Center](#) models will consider or include PROs as part of the performance measurement strategy. The Innovation Center is testing approaches to close care gaps and deliver whole-person care by driving progress in areas like integrated care, behavioral health, and SDOH. To measure progress, model participants will set improvement targets for use of patient-reported outcome and experience measures, helping to advance their use throughout CMS.

Give individuals access to their own health data and meaningful information.

To be effective partners in their care, individuals should have access to their own medical records and health data. CMS is working on implementing secure, standards-based Patient Access Application Programming Interfaces (APIs) that will allow patients easier access to their Medicare claims and encounter information, as well as relevant clinical information through a third-party application (app) of their choice. Depending on the specific app features, these tools

can help individuals have a better picture of all their interactions with the health care system, better manage their appointments and medication routines, learn more about their health conditions, and shop for Medicare Advantage plans that include their preferred providers. Various apps give individuals access to their health care information through all parts of the health care journey, even as they move from plan to plan and provider to provider.

CMS recognizes that language, health and health insurance literacy, and culture are key drivers of effective communication and have important impacts on overall quality of care and care management. CMS provides hands-on technical assistance and training support through the [QIO Program](#) to help providers implement the National Standards for [Culturally and Linguistically Appropriate Services \(CLAS\)](#) and meet the needs and preferences of individuals and families with culturally respectful and responsive person-centered care.

Provide a platform for public reporting.

In addition to better access to their own health data, individuals need access to information about how providers and facilities perform on quality and safety measures. For example, CMS provides the [Care Compare](#) website to help individuals with Medicare search for Medicare-approved providers, including hospitals, doctors and clinicians, inpatient rehabilitation facilities, nursing homes, home health services, dialysis facilities, and hospice care. Care Compare serves as a single source for individuals and their caregivers to search and compare information relevant for care decisions. CMS also provides a straightforward one- to five-star rating across different settings.

Spotlight on Action

- [QIOs](#) and the [CMS OMH](#) technical assistance program can assist providers in implementing the National CLAS Standards. Resources include guides to [implementing the National CLAS standards](#) and [developing a language access plan](#).
- CMS looks to hear feedback from various partners on changes to its programs or strategies. CMS collects this feedback through engagement events like [CMS National Stakeholder Calls](#) and [Open-Door Forums](#).
- The [CMS OMH](#) administers the [Minority Research Grant Program](#) to support researchers at minority-serving institutions that are examining how CMS can better meet the health care needs of racial and ethnic minority groups; people with disabilities; members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; individuals with limited English proficiency; individuals residing in rural areas; and individuals adversely affected by persistent poverty or inequality.



SAFETY

Achieve Zero Preventable Harm

Objective: Improve performance on key patient safety metrics through the application of CMS levers such as quality measurement, payment, health and safety standards, and quality improvement support.

The Safety goal of the CMS National Quality Strategy focuses on improving the delivery of safe care for all individuals through all levers available to CMS, including quality measurement, public reporting, payment incentives, standards and oversight, and quality improvement. CMS recognizes that preventable harm is [still too common](#). Progress toward meeting safety goals fell during the COVID-19 pandemic, which affected safety outcomes for patients and the health care workforce. Through enabling a deeply embedded safety culture, CMS is renewing its commitment to ensuring that the health care ecosystem has tools and solutions for a renewed focus on safety. CMS aims to return to pre-pandemic safety levels by 2025 and reduce preventable harm by an additional 25 percent by 2030.

In alignment with recommendations made to the President by the [President's Council of Advisors on Science and Technology](#) (PCAST), CMS is focusing its efforts on high-priority, preventable harms that are of greatest importance to individuals receiving their care through Agency programs. CMS will continue to focus on efforts to decrease health care-associated infections and healthcare-acquired complications, address medication events, and prevent maternal mortality and morbidity. CMS also is considering how the Agency may play a role in reducing diagnostic errors, health information technology-related errors, and abuse and neglect of vulnerable populations.

Although many safety initiatives have historically focused on inpatient care, CMS seeks to ensure that safety is a priority irrespective of where individuals receive care—whether in the hospital, at home, in LTC, or in community-based settings. Recognizing that harms may differ depending on setting of care, other approaches may be required to effectively address these harms. CMS recognizes that harm often occurs as individuals move from one setting of care to another, and therefore continues to seek policy solutions that address failures at these transition points, such as improving the use of interoperable data, advancing models to improve care coordination, and promoting implementation of evidence-based practices to ensure safe care transitions.

Key Actions to Drive Improvements in Safety and Reduce High-Priority Harms

- Expand transparency to increase accountability for safety.
- Drive improvements in safety through meaningful incentives, quality initiatives, and regulatory oversight.
- Promote safety initiatives that protect the health care workforce.
- Improve safe use and security of electronic health records and personal data.

Improving safety will require strong collaboration across industry and government. CMS works with other federal agencies and private sector partners to ensure the delivery of safe care across the continuum and to eliminate disparities in safety and quality. CMS is an active member of the [National Action Alliance](#) to Advance Patient Safety, a public-private collaboration to improve both patient and workforce safety. In addition, the [QIO Program](#) convenes Medicare patients, providers, and communities to collaborate on efforts to improve safety while considering local conditions and cultural factors.

Expand transparency to increase accountability for safety.

Publicly available information on quality and safety empowers individuals to make decisions about where to go for care and drives providers to improve care by understanding their performance in comparison to others. CMS uses a range of quality data for public reporting to encourage transparency to the public, with key health care safety data primarily available through the [Care Compare](#) tool. The [Cascade of Meaningful Measures](#) tool provides a list of safety measures that CMS uses to assess preventable harms to patients, safety culture, workforce and caregiver safety, and safety needs for special populations. The [CMS Measures Inventory Tool](#) includes specifications for each of these safety measures.

CMS is seeking to expand the reporting of safety measures across health care settings, including, for example, measures addressing healthcare-associated infections and nursing staffing levels to improve nursing home safety. To improve maternity care, CMS is increasing transparency involving hospital participation in a maternity care quality collaboration and implementation of recommendations to promote maternal safety. The [“Birthing-Friendly” publicly reported hospital designation](#) focuses on quality and safety and is the first-ever hospital designation that recognizes hospitals’ commitments to maternity care. CMS will use this designation to assess hospital leadership commitment to creating a culture of safety and eliminating preventable harm. CMS will continue to emphasize that safety is not just a hospital initiative, but that all settings, including ambulatory care, are critical to preventing harm.

CMS recognizes that transparency and engagement of individuals to support informed care decisions are key levers in improving outcomes. Meaningful discussions with individuals, families, and caregivers will produce safer care; thus, understanding them as critical partners and expanding their access to information related to their care and services is a key step toward improved safety outcomes.

Safety Goal Connections

- *How **Equity** Affects Safety:* Harms from unsafe care disproportionately affect individuals and communities already at higher risk of disparities in quality and outcomes. An increased focus on stratification of safety metrics, inclusion of all care settings in safety improvements, and prioritization of safety for these populations can help ensure that no individual experiences preventable harm.
- *How **Engagement** Affects Safety:* Initiatives to engage patients in safety efforts focus on enlisting them to detect adverse events, empowering their involvement in ensuring safe care, and emphasizing this as a means of improving the culture of safety. Use of cultural competence resources and practices and [National CLAS Standards](#) plays a critical role in safety. The combination of these resources, practices, and standards ensures that all individuals can effectively engage by considering language, health literacy, and the provision of culturally tailored services.
- *How **Interoperability** Affects Safety:* Interoperability is essential in enhancing safety by facilitating the timely and seamless exchange of data and metrics across care settings and between providers to support safety.
- *How **Scientific Advancement** Affects Safety:* CMS acknowledges the importance of proper safeguards to ensure the public can safely and securely benefit from growing advancements in science and technology. Technological advancements, including those in artificial intelligence, mean the Agency will seek new ways to effectively monitor safety and manage risks.

Drive improvements in safety through meaningful incentives, quality initiatives, and regulatory oversight.

CMS continues to strengthen incentives for health care providers to improve safety by rewarding high performers and penalizing those who do not meet safety standards through CMS' value-based quality programs that link payment to provider performance on measures. To address sepsis, for example, hospitals are now required to move beyond simply reporting on sepsis treatment measures and instead will be required to meet specific benchmarks in Medicare's Hospital Value-Based Purchasing Program to improve sepsis morbidity and mortality. These measures already demonstrate reduction in hospital length of stay, readmission rates, and mortality.

Recognizing that safety events are rarely the result of individual error, but rather reflect system-level flaws, CMS continues to support efforts to enable a holistic safety culture that includes sharing best practices, fostering leadership and governance that prioritize safety, and promoting data-driven decision making. Safety will remain a core aim of the [QIO Program](#) in its [draft 13th SoW](#), with specific focus on infection prevention and control, adverse drug events, and safety

events. The [QIO Program](#) will continue to emphasize implementation of evidence-based interventions through hands-on technical assistance to providers and communities.

CMS is strengthening the Agency's regulatory and oversight responsibilities to improve safety through the Quality Assessment and Performance Improvement (QAPI) program, as required by the Medicare Conditions of Participation (CoP). CMS updated guidance for the [hospital QAPI program](#) to reflect evidence-based practices and increase alignment on CoP requirements across settings. Hospitals with well-designed and well-maintained QAPI programs can significantly enhance their capability to provide high-quality and safe care, and therefore reduce the incidence of medical errors and adverse events throughout the hospital. The updated guidance focuses both on efforts to promote patient safety and reduce harm as well as ensuring the sustainability of quality initiatives.

Promote safety initiatives that protect the health care workforce.

CMS is committed to ensuring that health care workers have a safe working environment. Through its oversight responsibilities, the Agency has urged health care industry leaders to take steps to protect workers from [workplace violence](#). For example, CMS issued recommendations for leadership at health care facilities to prevent workplace violence in hospitals. Recommendations included ensuring that workers receive adequate training, that hospitals maintain sufficient staffing levels, that hospitals provide ongoing assessment of patients and residents for aggressive behavior and indicators, and that hospitals appropriately adapt patients' or residents' care interventions and environment. Finally, the [QIO Program's draft 13th SoW](#) intends to direct resources to impact health care workforce challenges by decreasing staff burden and burnout, addressing moral injury, and decreasing the risk of verbal abuse and physical violence.

Improve safe use and security of electronic health records and personal data.

CMS continues to focus on the advancement and safe use of EHRs through the [certified EHR technology requirements](#). To create a culture of safety, the [Medicare Promoting Interoperability Program and the MIPS Promoting Interoperability performance category](#) require participating hospitals and clinicians to complete a set of self-assessments to help health care organizations evaluate their EHR safety practices, identify potential risks, and mitigate those risks through the [Safety Assurance Factors for EHR Resilience \(SAFER\) guides](#). The safe and efficient use of EHRs can facilitate patient safety by ensuring that providers have the most complete data at the point of care.

Spotlight on Action

- The CMS [Cascade of Meaningful Measures](#) is used for prioritizing existing health care quality measures, aligning or reducing redundant measures, and identifying gaps where new measures are needed. Measures in the safety area include assessment of preventable harms to patients, organizational and workforce characteristics that support patient safety, and safety for special populations. These measures also assess safety culture as well as health care worker safety.
- CMS continues to prioritize safety in its latest work planning for the [QIO Program's draft 13th SoW](#). The [QIO Program](#) is dedicated to improving health care quality for Medicare beneficiaries. The QIOs will continue to prioritize safety efforts that target infection prevention and control, adverse drug events, and safety events. More information on current QIO activities is available at: [Quality Improvement Organizations | CMS](#)
- CMS publishes evidence-based resources on quality and safety improvements. Providers, accrediting organizations, advocacy groups, and the public can view resources available on the upgraded [Quality, Safety, & Education Portal Training Catalog](#). Guidance on specific harms, such as the [Toolkit for State Medicaid and CHIP Agencies on Increasing Access, Quality, and Equity in Postpartum Care in Medicaid and CHIP](#), is also available.
- The ["Birthing-Friendly" Hospital Designation](#) is a publicly reported, public-facing hospital designation on the quality and safety of maternity care. Individuals searching for high-quality, safe care can rely on this designation to select hospitals committed to perinatal quality and safety improvement activities.





RESILIENCY

Enable a Responsive and Resilient Health Care System to Improve Quality

Objective: Foster a more resilient health care system that is better prepared to respond to future emergencies.

The Resiliency goal of the CMS National Quality Strategy focuses on strengthening the preparedness of the health care system to respond to future emergencies. Supporting Health Care Resiliency is also a cross-cutting initiative of the [CMS Strategic Plan](#). CMS is working to support the underlying systems, people, processes, and infrastructure needed to ensure preparedness and adaptability to meet the challenges of the future.

Health care systems deliver care 24 hours a day, 365 days a year; crises like natural disasters, transportation challenges, and equipment and power failures can pose extraordinary obstacles to delivering care but must not prevent delivery of these services. The unprecedented COVID-19 pandemic exposed many weaknesses in our current health care system. While true heroes emerged from the pandemic response, relying on extraordinary efforts is not a sustainable solution. As the nation moves forward post-pandemic to ensure optimal health care operations, CMS is committed to partnering with others to build a more resilient delivery system, capable of providing high-quality, safe, and equitable care at all times, including during emergencies.

Key Actions to Support Health Care System Resiliency

- Build resiliency by addressing staffing and infrastructure needs.
- Support emergency response activities to enable providers to continue providing high-quality care through times of crisis.
- Address population and health care system needs during climate events.

To support a health care system that emerges stronger than before, CMS created a Cross-Cutting Initiative specifically dedicated to [Health Care System Resiliency](#) to ensure innovative solutions to strengthen emergency and disaster preparedness for the future. Resiliency requires cultural change across the system to empower the health care workforce and address workforce issues to reduce burnout and staff shortages. Workforce safety is an important component of enhancing workforce resilience and is discussed further under the CMS NQS Safety goal.

Resiliency Goal Connections

- *How **Scientific Advancement** Affects Resiliency:* Scientific advancements in predictive analytics will provide data tools to improve resource allocations and better inform emergency preparedness and response. This will lead to higher quality and safer care during normal operations as well as during crises.
- *How **Equity** Affects Resiliency:* Many communities experience disproportionate or repeated impacts of public health challenges and emergencies, both natural and human-caused. Stratification of quality measure data can identify differential effects of these emergencies to inform quality improvement efforts. Advancing health equity helps strengthen preparedness efforts, focuses policy efforts to ensure communities have adequate resources, and enhances the resilience of communities and health care systems.

Build resiliency by addressing staffing and infrastructure needs.

CMS is working to address workforce shortages and stabilize the health care workforce. One way to achieve this is through CMS funding for physician residency slots. CMS emphasizes expanding the pipeline of providers in primary care and mental health specialties to qualifying hospitals serving rural and underserved communities. CMS uses payment and incentive policies to support providers that treat populations with complex needs to ensure adequate resources to deliver needed care. CMS is also implementing additional policy changes to expand the behavioral health workforce and more accurately value and pay for behavioral health services. In partnership with states, CMS is investigating how to more efficiently integrate existing benefits and demonstrations in the Medicaid & CHIP programs with social services to expand the care team and alleviate the workload of clinical care providers.

The [CMS Innovation Center](#) is developing and implementing model tests that focus on [strengthening primary care infrastructure](#) such as AHEAD and MCP. These model tests will show how the Agency can better support these systems in maintaining financial viability to deliver vital care to a more geographically dispersed population. To address growing concern over rural hospital closures, CMS established a new Medicare provider type for [Rural Emergency Hospitals](#). Small rural hospitals and critical access hospitals that choose to convert to the Rural Emergency Hospital designation will receive additional payments for services, a monthly facility payment, and participation in a new quality incentive program. These additional resources will promote sustainability and support rural hospitals in continuing to provide high-quality, essential outpatient services, emergency services, and observation care for rural and underserved communities.

CMS also announced a national campaign to develop a resilient nursing home workforce. CMS continues to explore evidence-based policy options, such as minimum staffing standards for LTC facilities, to promote safe and high-quality care for the more than 1.2 million residents receiving care in Medicare and Medicaid-certified LTC facilities each day. Through its work with the Health Resources and Services Administration (HRSA) and other partners, CMS seeks to simplify the path to pursue careers in nursing homes. This staffing campaign builds on other actions through the [HHS Health Workforce Initiative](#), including the [HRSA Nursing Workforce Awards](#) to train more nurses and grow the nursing workforce.

Support emergency response activities to enable providers to continue providing high-quality care through times of crisis.

Previous national and public health emergencies, including extreme weather events, the opioid crisis, and the COVID-19 pandemic, have exposed concerns regarding the health care system's capacity. Under section 1135 of the Social Security Act, CMS can temporarily waive or modify certain Medicare and Medicaid & CHIP requirements to ensure sufficient health care services are available to meet the needs of individuals enrolled in those programs during emergencies. During the COVID-19 PHE, health care providers received maximum flexibility to streamline delivery and allow access to care. Because extreme weather and natural disasters can interfere with meeting quality program reporting requirements, CMS has a process to allow providers exceptions due to extraordinary circumstances. To better prepare for potential future emergencies, CMS is considering greater alignment of waivers and flexibilities across quality programs and ways to use stratified measure data to facilitate comparative analysis of impacts. CMS is also evaluating the effectiveness of CMS flexibilities in response to the COVID-19 PHE to inform potential future policy and program decisions to support a resilient health care system.

CMS is drawing on the experience and lessons of the pandemic to address emerging and unanticipated quality and safety concerns. New tasking in the [QIO Program's draft 13th SoW](#) will ensure that the QIOs will be positioned as the Agency's "ready resource" to be deployed as needed, adding much needed expertise and resources to providers facing unprecedented situations. Medicaid & CHIP also play a critical role in helping states and territories respond to PHEs, human-made disasters, and natural disasters. CMS offers a [disaster response toolkit](#) to help Medicaid & CHIP agencies prepare for and respond to these situations.

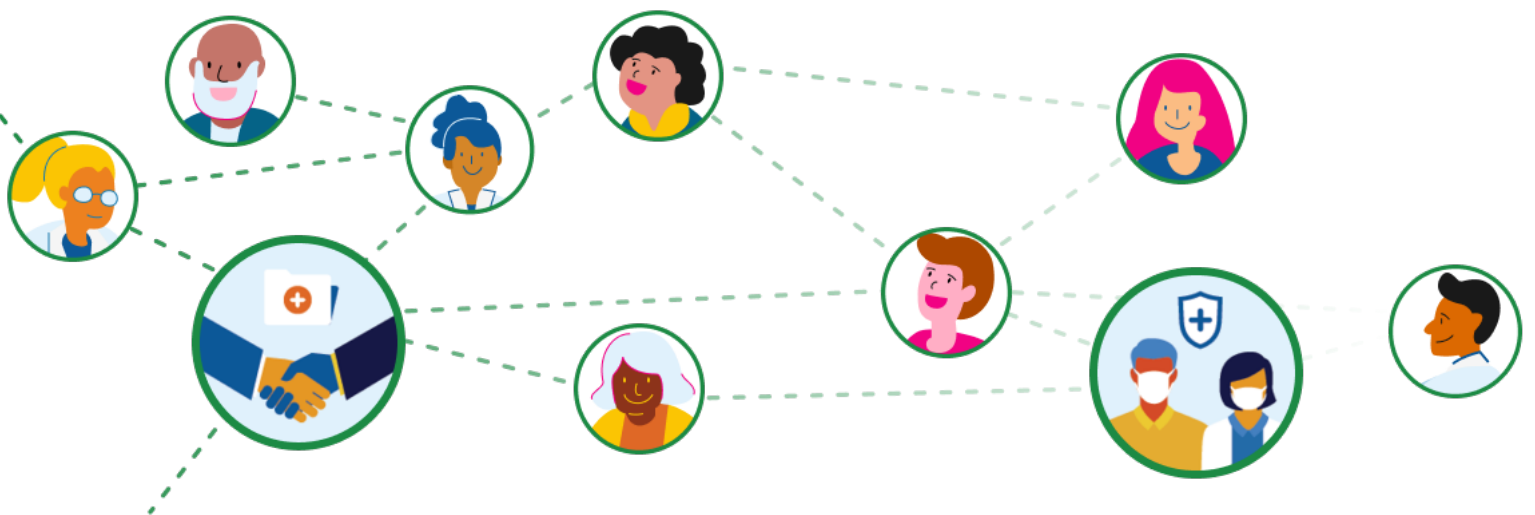
Address population and health care system needs during climate events.

Many PHEs can be attributed to extreme weather events, such as extreme heat, floods, storms, and poor air quality days, which create additional demand for health services and stress aging infrastructure. Climate change has an increasingly negative impact on health and the health care system's ability to address health needs. CMS safety and oversight regulations require providers to maintain compliance with emergency electric system standards. To facilitate innovation and flexibility, CMS issued a categorical waiver permitting health care facilities to use alternate sources of power, including microgrids, to enable health care organizations to begin work on ambitious emissions reduction and climate resilience goals.

Heat-related illness or complications from other conditions disproportionately affect certain individuals and communities. To address these needs, CMS is working in partnership across HHS to provide [innovative data and mapping tools](#) to help communities better plan for emergencies or disasters. Some [Medicare Advantage plans](#) increasingly cover air conditioners and air filters to address health needs related to heat and air quality and offer supplemental benefits for individuals with certain chronic conditions. In integrated care settings, some Medicare-Medicaid plans (MMP) are offering more services and supports for people experiencing social needs.

Spotlight on Action

- To strengthen primary care infrastructure for high-quality, whole-person care, the [CMS Innovation Center](#) launched [Making Care Primary](#), a model to provide a pathway for primary care providers to adopt prospective, population-based payments that stabilize practice revenues while they make investments to more seamlessly integrate behavioral and specialty care.
- CMS commits to incorporating CMS-specific quality actions consistent with the Office of the Assistant Secretary of Health (OASH) work on the [Federal Plan for Equitable Long-Term Recovery and Resilience \(Federal Plan for ELTRR\)](#). This plan focuses on cross-agency approaches to achieve enhanced resilience. CMS was a part of the 28 departments, agencies, and institutions that worked together on this plan.
- CMS partners with the Administration for Strategic Preparedness and Response (ASPR) on the [HHS emPOWER Program](#) to provide data, artificial intelligence tools, and training and resources to help communities better plan and address the needs of individuals in the event of an emergency or disaster. The emPOWER Map provides de-identified geospatial data on Medicare beneficiaries who use electricity-dependent durable medical and assistive equipment and may need assistance during an emergency. A related Medicaid & CHIP data pilot is assisting states and territories in developing resources for their pediatric and adult at-risk populations.





INTEROPERABILITY

Accelerate and Support the Transition to a Digital and Data-Driven Health Care System

Objective: Support data standardization and interoperability by developing and expanding requirements for sharing, receipt, and use of digital data, including digital quality measures, across CMS quality and value-based programs.

Data interoperability—or the capability of different information systems to securely exchange, access, and use data—allows those receiving care and those providing care to make data-driven decisions that are better informed and more efficient. Through improved interoperability of health care data, CMS can better evaluate whether the Agency’s programs provide health care that is equitable, safe, and of high quality.

The Interoperability goal of the CMS National Quality Strategy supports data standardization and interoperability across CMS by developing and expanding requirements for sharing, receiving, and using digital data. Data standardization ensures that data follows a common format applicable across systems and use cases. Digital data refers to data that is electronically generated from routine clinical workflows, such as information entered into EHRs or laboratory systems; administrative data, such as billing claims; and person-generated data, such as information from patient portals or wearable devices. Accelerating the transition to digital health data increases the types of data available to support care planning and treatment decisions while informing quality initiatives, reducing burden of data collection and reporting, and improving the timely access of data.

Key Actions to Promote Interoperability for Quality Efforts

- Champion the standards and technology needed for interoperability.
- Transition to digital quality measurement to advance interoperability.
- Promote organizational shifts and collaboration for interoperability readiness.

CMS policies and programs promote data standards to collect, analyze, and use data from all points in the health care system to drive better health care decisions that improve quality throughout a person’s care journey. Interoperability has many benefits across the health care system, including:

- Providers benefit from having the information that they need to support care and decision making, as well as the information needed to provide safe and coordinated care. Interoperability also reduces burden on providers to collect and report data, which allows them to focus on care.
- Individuals, families, and caregivers benefit by having access to meaningful health information to participate in informed discussions with providers.

- CMS benefits from the capability that interoperability contributes to support a learning culture. Capturing electronically generated data through clinical workflows enables continuous quality improvement and innovation processes that support data-driven research and grows the evidence base to achieve better health outcomes for individuals served by CMS programs.

Interoperability Goal Connections

- *How **Alignment** Affects Interoperability:* CMS works across the Agency and alongside federal partners, states, and the private sector to promote alignment on interoperability through standardization of data and tools. Harmonization ensures that CMS data are aligned with other use cases, which ultimately contributes to a high-quality health care system and reduces data collection burden.
- *How **Equity** Affects Interoperability:* Health care should be safe and equitable for all populations. The need to identify and reduce health disparities through rapid data analysis, standardization, and exchange across all providers, plans, settings, and community organizations in all locations is a key driver of success for interoperability.
- *How **Engagement** Affects Interoperability:* Giving individuals, families, and communities secure access to their own meaningful health information fosters better interactions with the health care system and promotes shared decision making. These data are often created across care settings and from interaction with the health system. Promoting more engagement depends on making interoperable data a reality across the continuum of care.
- *How **Safety** Affects Interoperability:* The risk of preventable harm increases when essential information is not received across all points of contact between individuals and the health system, and especially when individuals are navigating different care settings and payers. Interoperability can improve patient safety during care transitions by enabling data to follow the individual across care settings.

Champion the standards and technology needed for interoperability.

CMS works with many partners on developing and improving standards for interoperable data, including the Health Level 7 (HL7®) Fast Healthcare Interoperability Resources (FHIR®) standard. CMS collaborates with ONC on the development and maintenance of standards that promote nationwide, interoperable data exchange, including the [United States Core Data for Interoperability \(USCDI\)](#) and the USCDI+ Quality domain. USCDI defines a foundational set of interoperable data elements to aid in the exchange of standardized health information to support care and improve health care quality. The USCDI+ Quality domain provides additional interoperable data elements that are needed for CMS digital quality measures as well as other use cases across the federal government for FHIR-based quality reporting.

By using national standards like FHIR and USCDI, CMS leverages existing architecture that supports flexible and automated data exchange throughout the health care ecosystem and aligns with other federal initiatives. The flexibility and wide usage of the FHIR data standard also allow for access and exchange of information across the nation for a variety of use cases. For example, to address the need for better data across the care continuum, CMS co-founded the [Post-Acute Care InterOperability \(PACIO\) Project](#) that focuses on advancing interoperable health data exchange between providers of PAC and other providers, patients, community-based organizations, and key partners throughout the health care system. Established in 2019, the PACIO Project established a framework for developing FHIR implementation guides and other technical resources to facilitate the exchange of data through use case-driven, FHIR-based APIs.

The [CMS Office of Burden Reduction and Health Informatics \(OBRHI\)](#) drives changes within CMS to reduce administrative burden and advance interoperability and national standards. OBRHI spearheads and monitors CMS policies across Agency components to achieve improved interoperability in health care data exchange. Several burden reduction policies require USCDI data elements to be available through FHIR-based APIs. These policies ensure patients have better access to their health data and that providers and payers can share data across the continuum of care. CMS is also developing an Interoperability Strategic Framework to unite and guide current efforts across the Agency on the future path for interoperability in CMS programs and operations.

The [CMS Framework for Health Equity 2022–2032](#) recommends that standards development and implementation continue to support interoperable health equity data and address health disparities. USCDI version 2 and all subsequent versions of USCDI include an incrementally expanding list of data elements relevant to SDOH data collection, such as SDOH goals, problems and health concerns, and interventions. CMS co-sponsors the [Gravity Project](#), which includes more than 2,000 collaborators across the health care ecosystem. Gravity has developed a consensus-driven data standards framework to support exchange of SDOH data for health and social care interoperability. The focus on standardizing structured health equity data capture and exchange electronically can help advance CMS work in health equity while promoting alignment and harmonization, when possible, with other efforts across HHS.

Transition to digital quality measurement to advance interoperability.

CMS published a [Digital Quality Measurement \(dQM\) Strategic Roadmap](#) in March 2022, delineating the Agency's strategy to transition to digital quality measurement. Through this strategy, CMS will reduce data collection and reporting burden, while increasing the value of data collection. The dQM Strategic Roadmap calls for advancements in four domains: (1) Improve Data Quality, (2) Advance Technology, (3) Optimize Data Aggregation, and (4) Enable Measure Alignment. Data collected through dQMs can improve the ability to diagnosis diseases, aid in preventing medical errors, and improve safety and better health outcomes.

CMS incentivizes and promotes interoperability in various ways. Through the Quality Payment Program (QPP), CMS rewards Medicare providers that provide high-quality care and satisfy interoperable data requirements. Promoting Interoperability is a weighted scoring category as part of the QPP MIPS track. This category assesses the promotion of patient engagement and electronic exchange of health information using certified electronic health record technology (CEHRT). Eligible hospitals and critical access hospitals can participate in the Medicare Promoting Interoperability Program, which requires reporting on four scored objectives related to electronic prescribing, health information exchange, provider to patient exchange, and public health and clinical data exchange.

In addition to using incentive scoring to improve interoperability practices, CMS also uses program requirements to encourage the transition to digital quality measurement. According to the [2024 National Impact Assessment of CMS Quality Measures](#), as of 2023, 80 percent of measures in CMS quality programs had at least one option to use digital data sources, and several hospital and clinician quality programs include reporting requirements for [electronic clinical quality measures](#) (eCQM), which use data electronically extracted from EHRs. To support digital data exchange, CMS is exploring the possibility of transitioning to a FHIR-based receiving system, which would allow for a singular point of data submission to satisfy numerous quality reporting requirement purposes and be made available through FHIR-based APIs. CMS also established a new Medicare Clinical Quality Measure (CQM) collection type for accountable care organizations participating in the Medicare Shared Savings Program under the Alternative Payment Model Performance Pathway. This change will allow for Medicare CQMs to serve as a path to help ACOs build the infrastructure, skills, knowledge, and expertise needed to report all payer/all patient MIPS CQMs and eCQMs in the future. The [CMS Measures Inventory Tool](#) provides a preset filter option to easily view the latest eCQMs used in CMS programs.

CMS prioritizes supporting digital strategies and standards for data sources that are not yet fully digital and exploring the inclusion of data sources that have been traditionally outside of clinical quality measurement. CMS is focusing on impactful measures for digital transition. These are measures from the Adult and Child [Universal Foundation](#) measure sets and home- and community-based settings, as well as patient-reported outcomes in a digital, standardized format. In addition, CMS created the [Data Element Library \(DEL\)](#) to provide a centralized resource for CMS PAC assessment data elements. The DEL includes CMS PAC assessment questions, response options, and their related mappings to nationally accepted health IT

standards for Inpatient Rehabilitation Facilities, Home Health Agencies, Long-Term Care Hospitals, SNF and Nursing Homes, Hospice Care, and Home- and Community-Based Settings. Standardizing the content within each PAC setting's individual assessments and mapping the data element questions and response options to health IT standards support data interoperability. By maintaining consistency in format, meaning, and use of PAC assessment data elements, CMS facilitates data reuse for multiple purposes, including patient care planning and quality reporting. CMS recognizes the growing importance of health care data that comes from outside clinical settings, such as data from devices. For example, CMS monitors the work of the HL7® device community that focuses on a standard way for health care providers to obtain and analyze FHIR-based data outside of EHRs.

Promote organizational shifts and collaboration for interoperability readiness.

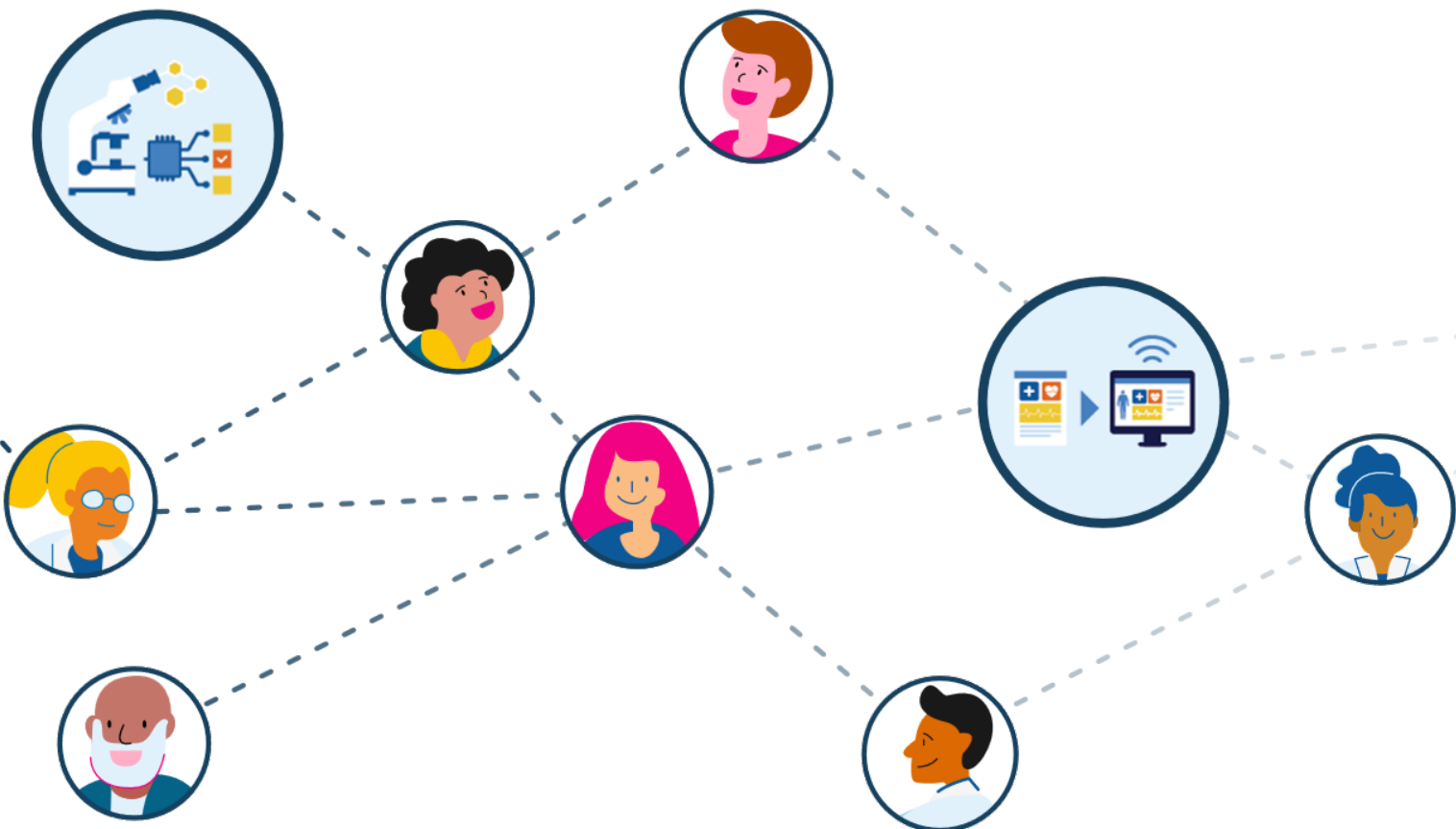
To advance interoperability within the Agency, CMS recognizes the need for shifts in organizational culture and support. CMS is committed to creating a health system that leverages the vast amount of information gathered throughout different points of the care journey and believes in the importance of bringing that information together in a meaningful way. This approach supports data analysis, rapid-cycle feedback, and improvements in quality measurement processes that push for advancements in whole-person, patient-centered care.

To support greater interoperability readiness, the [QIO Program's draft 13th SoW](#) includes a foundational aim to advance health care quality through technology. The [QIO Program](#) recognizes that organizations must assess their readiness to access and use health information technology; a critical first step is using readiness assessments to collect this information from providers. QIOs can then appropriately tailor evidence-based interventions for providers to improve organizational culture and underlying infrastructure.

Building and promoting an interoperable health system will require further alignment and engagement with key partners. CMS will continue to partner with the quality measurement community; work with standards-setting bodies like HL7®; collaborate with federal partners; and engage with community partners to align data needs, standards, and implementation considerations. With the advancements in standards and measurement technology, CMS recognizes the need to pursue further community involvement. Toward that end, CMS plans to gather feedback on the implementation of measures respecified to FHIR and methods of submission of data elements represented in FHIR through various venues. Beginning in 2020, CMS has collaborated with HL7® to host its own annual Connectathon, an educational event to share information about and solicit feedback on CMS activities related to FHIR.

Spotlight on Action

- CMS develops and maintains standardized patient assessment data elements that PAC providers must collect and report. The [CMS Data Element Library](#) assists in searching for these standardized data elements and their related mappings to nationally accepted health IT standards to support interoperable data sharing across the care continuum.
- The USCDI+ Quality data element list provides a framework for organizing data elements that support the exchange and use of data for quality measurement across programs and care settings as relevant to the [USCDI+ Quality](#) domain. The list aims to harmonize quality data elements and align policies for quality reporting programs, and to ultimately streamline the development and reporting of quality measures. Updated information about USCDI+ Quality data elements is available on the [USCDI+ Platform](#).
- The [Electronic Clinical Quality Improvement \(eCQI\) Resource Center](#) was created to bring together partners across the eCQI community and provide a centralized location for news, information, tools, and standards related to eCQI, eQMs, and dQMs. The [CMS Measures Inventory Tool](#) provides a preset filter option to easily view the latest eQMs used in CMS programs.





SCIENTIFIC ADVANCEMENT

Transform Health Care Using Science, Analytics, and Technology

Objective: Support and drive innovation and access through advanced data analytics and streamlined evidence-based reviews of novel technologies and devices for coverage decisions.

Advancements in science and technology have great potential to improve health care and outcomes. CMS has a crucial role in supporting scientific advancement and ensuring that the people it serves can receive these benefits. CMS acknowledges its responsibility to use appropriate guardrails to ensure that data and evidence appropriately support all scientific advancements to promote public safety.

The CMS National Quality Strategy focuses on strategies to support Scientific Advancement to drive quality improvement. These strategies support and align with the HHS Strategic Goal, [“Restore Trust and Accelerate Advancements in Science and Research for All,”](#) and the CMS Cross-Cutting Initiative, [Data to Drive Decision-Making](#). The Agency’s commitment to data and science that drive evidence-based practices and provide high-quality care applies across the CMS National Quality Strategy.

Key Actions to Drive Progress on Scientific Advancement

- Streamline the coverage review process for promising new technologies.
- Improve data available for research and evidence-based practice.
- Advance predictive analytics and tools, such as artificial intelligence, that may inform health care decisions.

Streamline the coverage approval process for promising new technologies.

CMS supports early, predictable, and safe beneficiary access to promising new medical technologies. When new treatments first come to market, they may not have been tested on the Medicare population and may not have sufficient evidence to support a favorable Medicare national coverage determination. When there is no national or local coverage determination, providers and beneficiaries may be uncertain whether Medicare will cover a new treatment. One way CMS can improve transparency and predictability of coverage decisions for promising new technologies with limited evidence in the Medicare population is through a national coverage determination (NCD) that includes coverage with evidence development (CED) requirements.

Scientific Advancement Goal Connections

- *How **Outcomes** Affects Scientific Advancement:* The need for safe, equitable, and high-quality care is the key driver behind efforts in scientific advancement. Setting a goal to improve high-priority health care outcomes can pave the way for the advancements needed in technology and systems to evaluate and measure key outcomes.
- *How **Interoperability** Affects Scientific Advancement:* Standardized, interoperable data and ways to access that data allow for new and innovative work around scientific advancements. Investments made in improving underlying data and infrastructure of health care data support advanced analytics and evidence-based practices throughout the agency.
- *How **Engagement** Affects Scientific Advancement:* Engagement is a core principle of the scientific advancement process. Having people throughout the health care system engaged in scientific advancement work can ensure that CMS is prioritizing meaningful, impactful work and prioritizes the individual's voice throughout the development of new tools and technologies.

Coverage under a CED NCD can expedite earlier beneficiary access for individuals who volunteer to participate in the clinical studies of innovative technologies. This approach ensures that systematic safeguards, including assurance that the technology is provided to clinically appropriate patients, are in place to reduce the risks inherent to new technologies or to new applications of older technologies. In general, CED enables providers and suppliers to perform high-quality studies that CMS expects will produce evidence that may support positive national coverage determinations.

CMS continues to streamline coverage review to further encourage innovation. In 2023, CMS announced the [Transitional Coverage for Emerging Technologies \(TCET\) pathway](#) for Food and Drug Administration–designated Breakthrough Devices. TCET supports improved care and innovation by providing a clear, transparent, and consistent coverage review process that promotes timelier Medicare beneficiary access to promising new technologies.

CMS is taking additional steps to increase transparency and improve the NCD and CED processes. In 2023, CMS proposed updated criteria for CED studies and proposed National Coverage Analysis Evidence Review guidance to clarify the principles CMS uses when evaluating evidence to support NCDs. CMS is also committed to publishing a series of guidance documents that identify important clinical outcomes for treatments addressing specific therapeutic areas. The first [proposed Clinical Endpoints Guidance document](#), published in June 2023, identifies the types of health outcomes and evidence CMS expects to review when making coverage determinations for knee osteoarthritis treatment. These guidance documents will encourage innovation and expedite access by improving transparency, predictability, and efficiency of evidence generation for parties seeking Medicare coverage for an item or service.

CMS is also testing innovative approaches to expand access to high-cost specialty therapies. The [CMS Innovation Center](#) has announced the [Cell & Gene Therapy Access Model](#), a Medicaid-focused model that will test the use of multi-state, outcomes-based payment arrangements to help improve coverage and access to potentially life-changing, high-cost specialty drugs and therapies, such as gene therapy for sickle cell disease (SCD). This is a key component of the [CMS Sickle Cell Disease Action Plan](#).

Improve data available for research and informing evidence-based practices.

With nearly 150 million Americans enrolled in Medicare and Medicaid & CHIP, CMS maintains one of the most robust health care data sets in the nation. CMS shares extensive data with the public and with researchers to promote transparency and generate insights into evidence-based practices.

CMS is improving its efforts to collect and share high-quality data to use in evidence-based decision making. As an example, CMS collects data on Medicaid & CHIP across U.S. states, territories, and the District of Columbia through the [Transformed Medicaid Statistical Information System](#) (T-MSIS). To make Medicaid & CHIP data more approachable for research, CMS created the T-MSIS Analytic File (TAF), which produces research-optimized versions of T-MSIS to support the broad research needs of data users. Using the T-MSIS TAF, CMS released a comprehensive overview of the impact of the [COVID-19 Public Health Emergency \(PHE\) on Medicaid & CHIP beneficiaries](#), which helps CMS and external partners in understanding the COVID-19 impacts. CMS is improving the quality of T-MSIS data by updating [DQ Atlas](#), a tool that helps users assess accuracy, reliability, and usability of data in the TAF. States can access additional data through the [Medicare-Medicaid Data Sharing Program](#) and the [State Data Resource Center](#).

Data quality is a foundation for using data for research and identifying evidence-based practices. CMS explores methodologies to assist with data completeness and imputation so that the data can be utilized to evaluate current programs. For example, the CMS Office of Minority Health supported the development of algorithms designed to indirectly estimate stratification variables for race and ethnicity, such as the [Medicare Bayesian Improved Surname Geocoding](#) method, currently used for quality measure data in several programs. CMS regularly reassesses methods that assist with imputing and improving race and ethnicity data. CMS is also evaluating public comments on how to expand the use of indirect estimation in its programs, such as applying similar methodologies in Medicaid & CHIP and the Marketplace.

Ongoing improvements in data practices enable providers to leverage data to improve quality and care outcomes. Numerous initiatives by states and QIOs rely on CMS data to build dashboards focusing on health equity and health quality. Within the QIO 12th SoW, one organization created an interactive health equity dashboard that allows users to visualize the health outcomes of individuals covered by Medicare stratified by race, ethnicity, gender, and disability status. Providers can use findings from the dashboard to focus improvement efforts on high-priority outcomes or individuals and communities that can benefit the most from

interventions. The [QIO Program's draft 13th SoW](#) emphasizes data analytic support to enable providers to use their data in quality and safety improvement efforts.

CMS will continue to expand the availability of and access to public use files for CMS data. In alignment with the Equity goal of the CMS National Quality Strategy, CMS funds grantees for the [Health Equity Data Research Program \(HEDAP\)](#) grant. The HEDAP grant makes it possible for grant recipients to access CMS-restricted data for minority health research. The [Minority Research Grant Program \(MRGP\)](#) helps support researchers at minority-serving institutions that research how CMS can improve safe and equitable health outcomes in high-priority focus areas, such as maternal health.

Advance predictive analytics and tools, such as artificial intelligence, that may inform health care decisions.

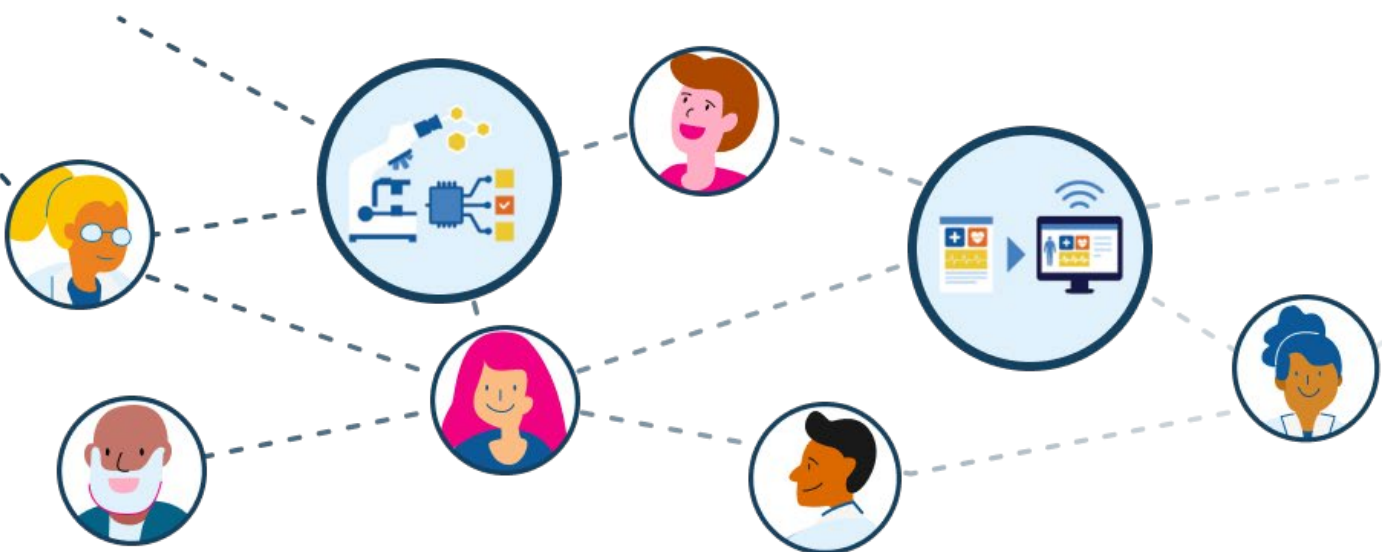
CMS continually uses, evaluates, and enhances analytical methods and models that support clinical care and quality efforts, such as the risk adjustment models used in Medicare plans. CMS updated the Medicare Part C risk adjustment model to include the latest diagnosis codes, cost, and clinically meaningful conditions based on clinician input. Updated models are evaluated to ensure better predictive accuracy for all demographic segments, including dually eligible individuals. CMS also [published guidance on how measure developers can use risk adjustment and stratification](#) to account for adjustment impacts on performance scores, a crucial consideration for CMS programs that rely on these scores to determine incentives or penalties.

CMS recognizes the potential of artificial intelligence (AI) and other predictive analytic methods to generate cost savings and better health outcomes. AI algorithms can enhance clinical decision support tools by learning from new data and staying current with the latest advances in research and guidelines. By providing consistent, evidence-based recommendations, AI can help reduce variability in care, which can lead to more consistent outcomes and improved overall quality of care. To ensure safe and equitable health care, CMS emphasizes the need to use AI responsibly and to monitor its use to reduce bias. This need aligns with multiple Executive Orders (EOs), national strategies, and federal guidelines that call for all autonomous systems to adhere to standards and guardrails for protecting the rights of all individuals and communities without exacerbating disparities. For example, CMS is committed to ensuring that the use of AI to improve health quality and outcomes adheres to evidence-based best practices and key design principles outlined in the [CMS AI Playbook](#). CMS will continue to model Agency best practices off nationwide guidance, such as the [National Institute of Science and Technology Risk Management Framework](#) and the [HHS Trustworthy AI Playbook](#).

In accordance with [Executive Order 13960 Promoting the Use of Trustworthy Artificial Intelligence in the Federal Government](#), CMS and other HHS agencies publicly document non-classified and non-sensitive [current or planned AI use cases](#), including use cases in quality, to foster public transparency and cross-agency collaboration. CMS will also adhere to Agency-specific requirements from [Executive Order 14110 Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence](#). This EO calls for risk management of federal agency AI usage to ensure that safe, secure, rights-respecting AI is adopted, deployed, and used. The EO requires agencies to prevent and address unlawful discrimination and other harms to equity that result from AI usage in programs and benefits administration.

Spotlight on Action

- The [CMS Medicare Coverage Database \(MCD\)](#) is a frequently updated, searchable repository that focuses on information pertaining to Medicare coverage. The MCD contains reports on both national and local coverage policies, downloadable data, related articles, references, and how-to guides, including the [How to Use the Medicare Coverage Database training](#).
- A list of CMS' currently published and comprehensive data sources is available on the [CMS data newsroom](#) webpage.
- [Data.CMS.gov](#) facilitates interactive analysis of publicly released CMS data to support data-driven practices. Data can be downloaded in multiple formats and accessed through an API to support real-time data access. The site also contains tools for looking up provider information, viewing interactive maps, and accessing CMS-created dashboards.



Call to Action



Through the CMS [National Quality Strategy](#), CMS strives to improve health care quality across the nation. To advance the NQS goals, CMS welcomes collaboration from government partners, health care payers and providers, and community-based organizations and, importantly, individuals, families, caregivers, and communities. In this “Call to Action,” CMS invites all partners to:

Prioritize the use of Universal Foundation measures.

CMS calls on private and public payers and providers to integrate the [Universal Foundation](#) to prioritize these clinical areas and reduce provider burden across the health care system. All partners can provide feedback on additional Universal Foundation measure sets by commenting on proposed rules and requests for information, and by participating in listening sessions and other public forums.

Commit to improving health care safety and reducing harm.

CMS urges government agencies and health care organizations to align with national-level safety recommendations, such as those made by the [President’s Council of Advisors on Science and Technology \(PCAST\)](#) and the [National Action Alliance to Advance Patient and Workforce Safety](#). Aligning with these recommendations enables CMS and its partners to focus on both reducing high-priority, preventable harms and adopting a systems approach to promote safer care. Individuals, families, and caregivers are essential partners in these efforts. Health care payers and providers should work with them to accomplish holistic safety improvement.

Advance health equity to improve health outcomes and eliminate disparities.

CMS asks states, payers, providers, and community-based organizations to partner in efforts to send consistent signals that quality cannot exist without equity. CMS is eager to collaborate on the implementation of equity-specific quality measures and on improving health equity data collection, standardization, and analysis to better understand and improve outcomes across all populations.

CMS will continue to share updates, provide resources, and gather feedback on efforts related to the key actions of the CMS National Quality Strategy. CMS is planning additional initiatives to advance the transition to digital quality measurement and to expand the use of person-reported outcomes. These and other future initiatives will depend on collaboration and partnership to be successful.

Together, CMS and its partners across the health ecosystem are putting **quality in motion** to achieve the mission of optimal safety, equity, health, and well-being for all individuals.

Acronyms

Term	Definition
ACO	Accountable Care Organization
AHEAD	All-Payer Health Equity Approaches and Development
AI	Artificial Intelligence
AI/AN	American Indian and Alaska Native
API	Application Programming Interface
ASPR	Administration for Strategic Preparedness and Response
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CED	Coverage with Evidence Development
CEHRT	Certified Electronic Health Record Technology
CHIP	Children’s Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services
CMS OMH	CMS Office of Minority Health
CoP	Medicare Conditions of Participation
CQM	Clinical Quality Measure
DEL	Data Element Library
dQM	Digital Quality Measurement
D-SNP	Dual Eligible Special Needs Plans
eCQI	Electronic Clinical Quality Improvement
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
ELTRR	Equitable Long-Term Recovery and Resilience
ESRD	End Stage Renal Disease
EO	Executive Order
FHIR®	Fast Healthcare Interoperability Resources
GUIDE	Guiding an Improved Dementia Experience
HCBS	Home- and Community-Based Services
HEDAP	Health Equity Data Access Program

Term	Definition
HHS	Department of Health and Human Services
HIV	Human Immunodeficiency Viruses
HL7®	Health Level 7
HRSA	Health Resources and Services Administration
HRSN	Health-Related Social Needs
IQR	Hospital Inpatient Quality Reporting
IT	Information Technology
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, and Queer
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MCD	Medicare Coverage Database
MCP	Making Care Primary
MIPS	Merit-based Incentive Payment System
MMP	Medicare-Medicaid Plans
MRGP	Minority Research Grant Program
MUC	Measures Under Consideration
MVP	MIPS Value Pathway
NCD	National Coverage Determination
NQS	National Quality Strategy
OASH	Office of the Assistant Secretary of Health
OBRHI	Office of Burden Reduction and Health Informatics
ONC	Office of the National Coordinator for Health IT
PAC	Post-Acute Care
PACE	Programs of All-Inclusive Care for the Elderly
PACIO	Post-Acute Care InterOperability
PCAST	President’s Council of Advisors on Science and Technology
PHE	Public Health Emergency
PPS	Prospective Payment System
PQM	Partnership for Quality Measurement
PRO	Person-Reported Outcomes

Term	Definition
PRO-PM	Person-Reported Outcomes and PRO-Based Performance Measures
QAPI	Quality Assessment and Performance Improvement program
QIO	Quality Improvement Organization
QIS	Quality Improvement Strategy
QPP	Quality Payment Program
REACH	Realizing Equity, Access, and Community Health
REUP	Rewarding Excellence for Underserved Populations
SAFER	Safety Assurance Factors for EHR Resilience
SCD	Sickle Cell Disease
SDOH	Social Determinants of Health
SNF	Skilled Nursing Facility
SoW	Statement of Work
TAF	Transformed Medicaid Statistical Information System (T-MSIS) Analytic File
TCET	Transitional Coverage for Emerging Technologies
T-MSIS	Transformed Medicaid Statistical Information System
USCDI	United States Core Data for Interoperability
VBP	Value-Based Purchasing