Appendix H – Related Programs and Initiatives

In addition to the quality measurement programs, CMS and other HHS agencies promote safety through a variety of initiatives that may also account for improvement in Key Indicator rates and the overall impacts identified for the respective priorities. Federal initiatives related to CMS quality priorities include:

PATIENT SAFETY

Hospital-Acquired Condition Reduction Program (HACRP)[1] – The HACRP subjects more poorly performing hospitals to payment reductions, effective beginning fiscal year (FY) 2015 (discharges beginning on October 1, 2014).[2] The goal is to use financial disincentives to change the care delivery process of providers to reduce some of the high-cost hospital-acquired conditions, including central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

Medicaid nonpayment policies for provider preventable conditions[1] – CMS issued regulations implementing Section 2702 of the Patient Protection and Affordable Care Act, which required the HHS Secretary to issue Medicaid regulations, effective July 1, 2011, that prohibit federal payments to states under section 1903 of the Social Security Act for any amounts expended to provide medical assistance for health care-acquired conditions specified in the regulation.[3(p. 32817-32818)]

Hospital Value-Based Purchasing Program[4] ***(HVBP)*** – The HVBP links Medicare payment adjustment for inpatient acute care services to measure performance and improvement in care quality for Medicare fee-for-service (FFS) beneficiaries and other patients.[5] A significant portion of the payment adjustment is tied to performance on patient safety measures.

Medicare Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) – The CMS National Patient Safety Initiative (NPSI) is a focused effort under the Medicare QIO program that was designed to protect patients by improving health care processes and systems. QIOs are focusing on six patient safety priorities: (1) Reduce rates of health care-associated methicillin-resistant Staphylococcus aureus (MRSA) infection; (2) Reduce rates of pressure ulcers in nursing homes; (3) Reduce rates of physical restraint use in nursing homes; (4) Improve inpatient surgical safety rates and heart failure treatment by hospitals; (5) Improve drug safety by reducing rates of drug-drug interactions and decreasing the prescription of potentially inappropriate medications; and (6) Provide intensive support to nursing homes most in need of assistance to improve care. [6]

Partnership for Patients (PfP) – The Partnership for Patients initiative is a public-private partnership working to make hospital care safer and less costly.[7] According to a December 2016 report released by HHS, the efforts to improve patient safety generated $28 billion in savings through a reduction in hospital-acquired conditions between 2010 and 2015. The reduction in hospital-acquired conditions is attributed in part to changes in Medicare payments to hospitals and the Partnership for Patients initiative.[8]

AHRQ Patient Safety Network (PSNet) – PSNet is a national Web-based resource that features news and essential resources on patient safety. The site offers information from patient safety literature, news, tools, and meetings ("What's New"), and hundreds of annotated links to

important research and other information on patient safety for researchers, clinicians, consumers, and policymakers.[9]

Medicare Patient Safety Monitoring System (MPSMS) – MPSMS is a nationwide surveillance project aimed at identifying the rates of specific adverse events in hospitalized patients. In the MPSMS project, an adverse event is defined as unintended patient harm, injury, or loss more likely associated with the patient's interaction with the health care delivery system than with an attendant disease process.[10]

Healthy People 2020 – Healthy People 2020 is a collaborative process between HHS and other public stakeholders that was designed to provide science-based, 10-year national objectives for improving health. Healthy People 2020 has established benchmarks and monitored progress over time to encourage collaboration across communities and sectors and empower individuals toward many health objectives, including patient safety.[11]

Surviving Sepsis Campaign measures – The National Quality Forum (NQF) ratified the measures for the treatment and management of patients with severe sepsis and septic shock. Measures ratified by NQF are considered by CMS for public reporting and payment programs.[12]

PERSON AND FAMILY ENGAGEMENT

Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) – QIN-QIOs help community stakeholders, providers, patients, and families organize to improve discharge communication, coordination of care transitions, and access to community services. Initiatives such as the Everyone with Diabetes Counts (EDC) program are designed to give each person with diabetes and his or her family an active role in care.[13,14]

Home and Community Based Services (HCBS) enhancements – Engagement of individuals is facilitated by the development and testing of various experience of care surveys, including those for people more difficult to query, such as persons using HCBS.[14] It is also facilitated by requiring systems that deliver home and community based services to develop and use person-centered service plans. The final rule published January 10, 2014, ensures that individuals receiving services and supports through Medicaid's HCBS programs have meaningful access to their surrounding community and the services are based upon a strong foundation of person-centered planning and approaches to service delivery.[15]

CMS Compare sites – CMS publishes information about the quality of care across health care settings that most families encounter. The information includes quality data. Compare sites include Hospital Compare, Nursing Home Compare, Physician Compare, Medicare Plan Finder, Dialysis Facility Compare, Home Health Compare, Hospice Compare, Long-Term Care Hospital Compare, and Inpatient Rehabilitation Facility Compare. CMS is adopting Five Star Ratings across all Medicare.gov Compare websites to help consumers make more informed decisions about where to get health care.[16,17]

Partnership for Patients (PfP) – The Partnership for Patients initiative is a public-private partnership that advances the priority areas of safety, care coordination, and patient and family engagement.[18] The partnership encourages and supports patients and families to be active participants in their care and decision-making at whatever level they feel comfortable.[19]

CMS Person and Family Engagement (PFE) Strategy – The PFE Strategy outlines key tenets, foundational principles, and values of person and family engagement, and highlights the importance of collaboration and partnerships to reach the specified goals. The PFE Strategy,

developed by CMS, takes into consideration work done across HHS, and input from key stakeholders, including patient advocacy groups, associations, providers, and caregivers.[20]

Transforming Clinical Practice Initiative (TCPI) – One of the three primary drivers of TCPI is person- and family-centered care design. Such an approach encourages clinicians to consider the voices of the patient and family along with evidence-based care practices.[21,22]

CARE COORDINATION

Accountable Care Organizations (ACOs)[23] – The goal of an ACO is to unite groups of clinicians, hospitals, and other health care providers voluntarily to give high-quality, coordinated, timely care to Medicare beneficiaries while avoiding duplication of services and preventing medical errors.[24] ACO initiatives reward success toward this goal financially. Examples of Medicare ACOs include the Medicare Shared Savings Program and the Innovation Center Pioneer ACO model and Advanced Payment ACO model.

Bundled Payments for Care Improvement (BPCI) Initiative – Implemented by the Center for Medicare and Medicaid Innovation (Innovation Center), BPCI links payments for the multiple services that beneficiaries receive during an episode of care. These models may lead to higher quality of care, including greater care coordination, and result in cost savings.[25]

Financial Alignment Initiative[26] – Financial misalignment is a long-standing barrier to Medicare-Medicaid coordination. In 2011, CMS announced two new models to support care coordination for the dual-eligible population. Through the Financial Alignment Initiative, CMS is working with states to test a capitated model and a managed fee-for-service model to integrate primary, acute, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees and to better align the financing of the two programs.[27]

Hospital Readmissions Reduction Program (HRRP)[28] **–** The HRRP encourages care coordination by focusing on excess readmissions. Medicare reduces payments to hospitals with excess readmissions for specified conditions, compared with the national average for such conditions, as adjusted for the specific patient mix of a hospital.[29]

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Unnecessary hospitalizations can be expensive, disruptive, and disorienting to frail elders and people with disabilities. This initiative is focused on long-stay residents enrolled in both the Medicare and Medicaid programs. CMS funded seven "enhanced care and coordination provider" (ECCP) organizations to test strategies to reduce avoidable hospital admissions through evidence-based clinical and educational interventions.[30]

Medicaid Health Home State Plan Option – The Patient Protection and Affordable Care Act created an optional Medicaid State Plan benefit for states to establish health homes to coordinate care of beneficiaries with chronic conditions. CMS expects state health home providers to operate under a "whole person" philosophy, integrating and coordinating all primary, acute, behavioral health, and long-term services and supports.[31]

Medicaid Innovation Accelerator Program (IAP) – IAP supports improved care for beneficiaries with multiple health care needs, such as those with substance use disorders (SUDs) and complex medical conditions. The program also supports the efforts of states to accelerate payment and service delivery reforms. The goal is to reduce costs for the Medicaid program and enhance care coordination by providing additional federal tools and resources and by sharing lessons and best practices.[32]

Medicare Advantage Organization (MAO) Quality Improvement Projects (QIPs) – These projects are intended to improve care coordination, which includes a focus on home visits, reduced all-cause hospital readmissions, community partnerships, and follow-up primary care provider (PCP) visits within seven days of discharge.[33] These projects are a part of the overall requirement that MAOs have a quality improvement program (QIP). In a Notice of Proposed Rulemaking published Nov 28, 2017, CMS proposed to eliminate the QIP requirement.[34(p. 56454-56455)]

Medicare and Medicaid Electronic Health Record Incentive Programs (EHR Incentive Programs) – Stage 2 criteria incorporated into the EHR Incentive Programs are intended to encourage the use of health information technology for continuous quality improvement at the point of care and exchange of information in the most structured format possible. Participants are required to electronically transmit patient care summaries to support transitions in care.[35(p. 54020)]

Merit-based Incentive Payment System (MIPS) – MIPS, launched with an initial performance period in 2017, encourages care coordination as a priority identified by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MIPS uses care coordination measures and improvement activities to foster timely communication of test results, timely exchange of clinical information to the patient and other providers, and use of remote monitoring or telehealth.[36]

Partnership for Patients (PfP) – Goals of this HHS initiative include improving transitions of Medicare beneficiaries from inpatient hospitals to other care settings and reducing readmissions for high-risk patients.[37,38]

Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) – QIN-QIOs help community stakeholders, providers, patients, and families organize to improve coordination of care transitions, discharge communication, and access to community services. QIN-QIOs promote evidence-based approaches to improve care, especially in vulnerable populations affected by poor care coordination. Interventions to reduce avoidable hospital readmissions are examples of these initiatives.[39]

State Innovation Models (SIM) Initiative – SIM provides assistance to state-led, multi-payer efforts to design and test innovative models of payment and service delivery that will improve care for residents of participating states and reduce costs to CMS programs.[40]

Test Experience and Functional Tools (TEFT) grant program – CMS awarded TEFT planning grants to states to test quality measurement tools and demonstrate e-health in Medicaid community-based long-term services and supports (CB-LTSS) with the objective of improving care coordination and care management.[41]

EFFECTIVE TREATMENT

Accountable Health Care Communities Model – This Center for Medicare & Medicaid Innovation (Innovation Center) model promotes collaboration between clinicians and the community to identify and address health-related social needs of Medicare and/or Medicaid beneficiaries that may increase their risk of chronic conditions, reduce their ability to manage the conditions effectively, increase health care costs, and lead to avoidable health care utilization.[42]

Bundled Payments for Care Improvement (BPCI) Initiative – The Innovation Center implemented this initiative to test the impact of linking payments for the multiple services that

beneficiaries receive during an episode of care. These models may lead to higher quality of care, including greater care coordination, and result in cost savings.[43]

Chronic Conditions Data – CMS has developed a set of information products to assist researchers, policymakers, and other interested parties in understanding the burden of chronic illness in the Medicare population. Information on the prevalence, utilization, and Medicare spending for 19 specific chronic conditions and multiple chronic conditions aids research into the impact of these conditions.[44]

HHS Initiative on Multiple Chronic Conditions (MCC) – Recognizing the importance of MCC to patients, families, caregivers, and the health care system, the Assistant Secretary for Health convened an HHS-wide work group to identify options for improving the health of this population,[45]in which CMS actively participates.

Healthy People 2020 – Healthy People 2020, an HHS initiative, is coordinated by the CDC National Center for Health Statistics. CMS programs incorporate measures used by Healthy People 2020.[46]

Home and Community-Based Services (HCBS) Enhancements – Facilitating HCBS encourages the use of proven self-care management. The final rule published January 10, 2014, offers states flexibility in providing necessary and appropriate services to elderly and disabled populations and ensures that individuals receiving services and supports through the Medicaid HCBS programs have full access to the benefits of community living.[15]

Hospital Value-Based Purchasing Program[4] ***(HVBP) –***Initiatives such as the Hospital Value-Based Purchasing Program compensate providers, in part, based on the quality rather than the quantity of care.[47]

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Unnecessary hospitalizations can be expensive, disruptive, and disorienting to frail elders and people with disabilities. This initiative is focused on long-stay residents enrolled in both the Medicare and Medicaid programs. CMS funded seven "enhanced care and coordination provider" (ECCP) organizations to test strategies to reduce avoidable hospital admissions through evidence-based clinical and educational interventions.[30]

Medicare Advantage Chronic Care Quality Improvement Activities – The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)[48]requires Medicare Advantage Organizations to conduct quality improvement activities to promote effective management of chronic disease. MMA designated specific segments of the population, such as beneficiaries with severe or disabling chronic conditions, that would benefit from Medicare Advantage Special Needs Plans.[49]

Million Hearts® Cardiovascular Disease Risk Reduction Model – CMS and the CDC co-lead the Million Hearts® initiative in partnership with other federal agencies. The goal of the initiative is to reduce the incidence of heart attacks and strokes by 1 million by 2017. The Innovation Center in 2017 implemented the Cardiovascular Disease (CVD) Risk Reduction Model, which is expected to reach more than 3.3 million Medicare fee-for-service beneficiaries who have not had a previous heart attack or stroke over a five-year period.[50,51]

***Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs*) –** QIN-QIOs work under the direction of CMS to "improve quality and efficiency of care for Medicare beneficiaries."[52] One QIN-QIO goal is to work with physicians to provide more effective

treatment to patients at risk for heart attack and stroke, especially those in underserved populations. Additionally, the Strategic Innovation Engine (SIE) under the QIO program promotes innovative practices that result in improved care or reduced health care spending to manage patients with multiple chronic conditions—specifically heart disease, diabetes, and high blood pressure.[53]

HEALTHY LIVING

Accountable Health Care Communities Model – The Center for Medicare & Medicaid Innovation (Innovation Center) model promotes collaboration between clinicians and the community to identify and address health-related social needs of Medicare and/or Medicaid beneficiaries that may increase their risk of chronic conditions, reduce their ability to manage the conditions effectively, increase health care costs, and lead to avoidable health care utilization.[42]

Health Improvement Navigator Program – The Centers for Disease Control and Prevention (CDC) Community Health Improvement Navigator program provides tools and resources for collaborative approaches to community health improvement, establishes and maintains effective collaborations, and finds interventions that work for the greatest impact on health and well-being.[54]

Healthy People 2020 – Healthy People 2020 is a collaborative process among HHS, other federal agencies, public stakeholders, and an advisory committee designed to provide science-based, 10-year national objectives for improving health. Healthy People 2020 has established benchmarks and monitored progress over time to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions, and measure the impact of prevention activities.[55]

National Prevention Strategy – The overarching goal of the strategy from the Surgeon General is to increase the number of Americans who are healthy at every stage of life. Evidence-based recommendations aim to achieve four broad strategic directions: build healthy and safe environments, expand quality preventive services, empower people to make healthy choices, and eliminate health disparities.[56]

Partnerships to Improve Community Health – This CDC initiative supports implementation of evidence-based strategies to improve the health of communities and reduce the prevalence of chronic disease. Community awardees are implementing population-based strategies tailored to their individual community needs to create greater access to healthier environments, e.g., protecting people from secondhand smoke exposure in indoor and outdoor spaces and promoting nutrition guidelines that encourage healthy food and beverage options in schools and worksites.[57]

Racial and Ethnic Approaches to Community Health (REACH) – REACH is a national program administered by the CDC to reduce racial and ethnic health disparities. [58] Through REACH, awardee partners plan and carry out local, culturally appropriate programs to address a wide range of health issues among various racial and ethnic groups.[59]

AFFORDABLE CARE

Center for Medicare and Medicaid Innovation (Innovation Center) – The Innovation Center, established by the Patient Protection and Affordable Care Act, allows CMS to develop and test "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care."[60,61] The Innovation Center models initiatives are organized into seven categories: accountable care organizations and similar care delivery

arrangements, episode-based payments, primary care transformation, Medicaid and Children's Health Insurance Program (CHIP) populations, dually eligible Medicare-Medicaid populations, accelerated development of new payment and service delivery models, and adoption of best practices.[62]

Health Care Fraud and Abuse Control Program (HCFAC) – The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[63] established a national HCFAC to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Under the joint direction of the Attorney General and the HHS Secretary, the program has returned more than $29.4 billion to the Medicare Trust Funds since its inception. In the past fiscal year, the HCFAC returned $6.10 for each dollar invested.[64]

Health Care Payment Learning & Action Network (HCP-LAN) – The HCP-LAN was launched in 2015 to support alignment by public and private sector stakeholders in shifting away from the current FFS, volume-based payment system to one that pays for high-quality care and improved health.[65] Participants share new ideas to achieve system wide improvements and payment reforms across private and public sectors.[66] The HCP-LAN has produced methodology recommendations for population- and clinical episode-based payment models.[67]

Medicare Provider Utilization and Payment Data – CMS released data files that summarize utilization and payments for procedures, services, and prescription drugs provided to Medicare beneficiaries. The files contain information for common hospital inpatient and outpatient services, all physician and other supplier procedures and services, and all Part D prescriptions. CMS also provides utilization and payment files for skilled nursing facilities, hospice providers, and durable medical equipment suppliers. The data are public information that can be used in publications without seeking approval from CMS.[68]

Qualified Entity (QE) Program – Also known as the Medicare Data Sharing for Performance Measurement Program, the QE program was established by the Affordable Care Act and implemented in 2011. A QE may receive and use Medicare Parts A, B, and D claims data to produce and publicly disseminate reports on provider performance. QEs must combine the Medicare data with data from other sources to evaluate performance of providers and suppliers on measures of quality, efficiency, effectiveness, and resource use. CMS selects and monitors organizations participating in this program.[69,70]

Partnership for Patients (PfP) – The Partnership for Patients initiative is a public-private partnership working to make hospital care safer and less costly.[7] According to the December 2016 report released by HHS, the efforts to improve patient safety generated $28 billion in savings through a reduction in hospital-acquired conditions between 2010 and 2015. The reduction in HACs is attributed in part to changes in Medicare payments to hospitals and the Partnership for Patients initiative.[8]

Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) – QIN-QIOs help community stakeholders, providers, patients, and families organize to improve discharge communication, coordination of care transitions, and access to community services. One of the goals of the work performed by QIN-QIOs is to make care more affordable by identifying how providers may furnish more efficient and economical quality care.[39] QIN-QIOs help providers earn incentive payments tied to reporting on measures that assess clinical quality of care, care coordination, patient safety, and patient and caregiver experience of care. QIN-QIOs also help

hospitals, physician practices, and other providers improve quality of care and use health information technology effectively to achieve system-wide efficiency and lower costs.

Transforming Clinical Practice Initiative (TCPI) – In September 2015, CMS announced $685 million in awards to 39 national and regional health care transformation networks and supporting organizations for the Transforming Clinical Practice Initiative.[71] The initiative is designed to equip more than 140,000 clinicians with the tools and support they need to improve quality of care, increase patient access to information, and reduce costs. TCPI is one of the largest federal investments designed to support doctors and other clinicians nationwide through collaborative and peer-based learning networks.[71,72]

Value-based purchasing (VBP) programs – CMS implements value-based purchasing (VBP) programs in a number of health care settings, including the End-Stage Renal Disease Quality Incentive Program (ESRD-QIP), Hospital Value-Based Purchasing Program (HVBP), Hospital Readmission Reduction Program (HRRP), Hospital-Acquired Condition Reduction Program (HACRP), Skilled Nursing Facility VBP Program, and Quality Payment Program for eligible clinicians. This reflects a shift from reimbursement based wholly on fee-for-service to value-based systems. In the fee-for-service model, practitioners and organizations are incentivized to provide greater quantities of services to generate higher reimbursement. The value-based model ties payment to components of quality of care, including appropriate utilization and efficiency, with the goal of improving beneficiaries' experiences and outcomes. As a result, CMS expects that payment adjustments under a value-based system will reward improved quality and penalize poor performance to achieve a more sustainable payment system.[47]

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