The CMS Equity Plan for Improving Quality in Medicare

Centers for Medicare & Medicaid Services

Office of Minority Health

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Introduction

The Centers for Medicare & Medicaid Services (CMS) Equity Plan for Improving Quality in Medicare (*CMS Equity Plan for Medicare*) provides an action-oriented, results-driven approach for advancing health equity by improving the quality of care in Medicare. The CMS Office of Minority Health (CMS OMH), in collaboration with NORC at the University of Chicago, produced this plan as part of its broad range of work to achieve health equity. The purpose of the *CMS Equity Plan for Medicare* is to position CMS to support Quality Improvement Networks and Quality Improvement Organizations (QIN-QIOs); Hospital Engagement Networks (HENs); federal, state, and local government agencies; providers; researchers; policymakers; beneficiaries and their families; and other stakeholders in activities to achieve health equity. The priorities and activities described in this document were identified during a year-long process which included examining the evidence base, identifying opportunities, and gathering stakeholder input.

Why do we need a CMS Equity Plan for Medicare?

As health care delivery system reform continues, CMS has an important opportunity and a critical role to play in increasing health equity. Across the agency, CMS uses policy levers and program authorities to develop innovative solutions that support access to high quality care, promote health care system efficiency, and ensure affordable health coverage. Simultaneously, the agency is committed to leveraging its unique role to encourage action among stakeholders and partners to fulfill the health equity goals set forth in the U.S. Department of Health and Human Services (HHS) Action Plan to Reduce Racial and Ethnic Disparities, the CMS Strategy, and the CMS Quality Strategy. In line with CMS' continuous drive toward quality improvement, the *CMS Equity Plan for Medicare* outlines the agency's path to sustained progress on increasing health equity among Medicare beneficiaries.

Who does the plan impact?

This plan focuses on Medicare populations that experience disproportionately high burdens of disease, worse quality of care, and barriers to accessing care. Priority populations include racial and ethnic minorities, sexual and gender minorities, and persons with disabilities. The *CMS Equity Plan for Medicare* was also developed with particular attention to disparities in chronic diseases such as diabetes, chronic kidney disease, and cardiovascular disease. Chronic conditions pose a significant human and financial burden, are prevalent in the Medicare population, and are likely to co-occur. Further, these chronic diseases represent important areas of focus for the QIN-QIOs.

How did we develop the CMS Equity Plan for Medicare?

We created a unifying framework to guide the development, implementation, and evaluation of the priorities and activities in the *CMS Equity Plan for Medicare*. The framework consists of three interconnected domains which provide a foundation for the plan's priorities and activities. The domains include: increasing **understanding and awareness** of disparities, creating and sharing **solutions**, and accelerating implementation of effective **actions**. This framework,

detailed in the following section, recognizes that achieving equity will require a continuous improvement cycle — filling knowledge gaps, identifying best practices, and supporting action, then coming back full circle to monitor improvements and change, identify new gaps, and begin the improvement cycle again.

We identified six high-impact priority areas based on a review of the evidence base and stakeholder input. We evaluated potential areas of focus within CMS' purview and aligned with existing CMS and HHS initiatives, paying particular attention to how CMS could further support QIN-QIOs. The set of six priority areas are listed in **Exhibit 1** and described below. These priorities encompass both system- and community-level approaches to achieve equity in Medicare. We are developing specific activities within each priority area. Activities will fall into the domains in our framework—**understanding and awareness**, **solutions**, and **actions** —giving focus to our vision and measures of success.

Exhibit 1: *CMS Equity Plan for Medicare* Priority Areas

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Evaluate Disparities Impacts and Integrate Equity Solutions Across CMS Programs

Priority 3: Develop and Disseminate Promising Approaches to Reduce Health Disparities

Priority 4: Increase the Ability of the Health Care Workforce to Meet the Needs of Vulnerable Populations

Priority 5: Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities

Priority 6: Increase Physical Accessibility of Health Care Facilities

How will we measure success?

In order to assess and document our progress towards increasing equity in Medicare quality, we will design a robust evaluation, tailored to the priorities and specific activities implemented from the *CMS Equity Plan for Medicare*. The evaluation will align with and reflect each level of our equity framework of **understanding and awareness**, **solutions,** and **actions**. We will identify, establish, and track specific performance metrics to assess progress across priorities and activities. Inherent in this evaluation is a continuous quality improvement process and feedback loop that will be used to make changes, when needed, and show improvement over time.

Strategic Approach

The U.S. has made progress towards improving health care quality, but well-documented disparities persist for racial and ethnic minorities, and the health care system does not fully address the needs of sexual and gender minorities or persons with disabilities. Reducing disparities is identified as a national priority, called out in the HHS Disparities Action Plan, Healthy People 2020, the CMS Strategy, the CMS Quality Strategy, and key provisions in the Affordable Care Act (ACA). CMS can continue to move the nation toward health equity by identifying and disseminating new and promising practices, leveraging existing work to increase our impact on health equity, facilitating knowledge sharing and collaboration among stakeholders, and engaging with new audiences to expand the network of stakeholders working

to achieve equity. In particular, CMS can leverage the ongoing efforts of QIN-QIOs to support and amplify programs that have been proven to reduce disparities.

ALIGNMENT WITH CMS GOALS

The CMS Quality Strategy details agency priorities for quality improvement and identifies the elimination of disparities as one of four foundational principles. The *CMS Equity Plan for Medicare* sets forth a plan for CMS to meet this objective. **Exhibit 2**[i] presents the goals and foundational principles of the CMS Quality Strategy.

Exhibit 2: CMS Quality Strategy Goals

The *CMS Equity Plan for Medicare* also addresses the other foundational principles, particularly strengthening infrastructure and data systems. Being able to monitor trends in quality of care and health outcomes is essential to increasing health equity in priority populations and disease areas.

CMS LEVERS

The *CMS Equity Plan for Medicare* will effect change through several important mechanisms. This set of levers, unique to CMS, encompasses the core CMS functions and resources the agency and stakeholders will use to implement the *CMS Equity Plan for Medicare*. The levers include:

- QIN-QIOs
- CMS Programs
- Policy
- Data
- Access to Stakeholders
- Communication Tools

GUIDING FRAMEWORK

The three interconnected domains of our guiding framework provide a foundation for the plan's priorities and activities. We envision this framework as a cycle of quality improvement, continuously driving toward better **understanding and awareness** of disparities, identifying and creating **solutions** based on that understanding, and accelerating the implementation of measurable **actions** to achieve health equity. Throughout this process, we will evaluate, adjust, and revise our process to continue advancing equity in Medicare quality.

The **understanding and awareness** domain is focused on:

- Increasing understanding and awareness of disparities
- Improving understanding of why disparities matter and why it is important to address them
- Enhancing understanding of the causes of disparities
- Identifying knowledge gaps

The **solutions** domain is focused on:

- Creating new solutions based on our understanding of disparities
- Testing promising strategies and interventions
- Sharing tools with stakeholders

The **actions** domain is focused on:

- Garnering support and action from a variety of stakeholders
- Supporting stakeholders in their efforts to achieve health equity
- Making adjustments for continued success
- Ensuring actions are sustained over time

MEASURING SUCCESS IN THE *CMS EQUITY PLAN FOR MEDICARE*

We will measure the success of the *CMS Equity Plan for Medicare* using our framework as a guide. To monitor our progress toward increasing equity in Medicare quality, we have developed three interconnected evaluation questions:

1. How are the activities in the *CMS Equity Plan for Medicare* increasing **understanding and awareness** of disparities and their causes?
2. How are the activities in the *CMS Equity Plan for Medicare* creating, testing, and implementing **solutions** to increase equity in Medicare quality?
3. How are the activities in the *CMS Equity Plan for Medicare* leading to **actions** that increase equity in Medicare quality?

To measure progress in the *CMS Equity Plan for Medicare*, we will implement two levels of monitoring and evaluation and answer three evaluation questions to assess how we are doing in increasing equity **understanding and awareness**, **solutions**, and **actions**. Monitoring and evaluation activities will occur at the priority and activity levels, to give us a micro and macro view of our progress.

Priority-Level Evaluation. We will assess the extent to which progress is being made in the six priority areas as they relate to the framework. Specifically, for each priority area, we will identify measures to track progress towards increasing **understanding and awareness** of disparities and their causes; creating, testing and implementing **solutions**; and galvanizing **actions** to increase health equity:

- ***Measures for increasing understanding and awareness of disparities*** may include the number and types of stakeholders that have participated in activities within the priority area; the number of people reached through outreach and engagement; and the awareness and reach of existing tools, products, and data.
- ***Measures for creating, testing, and implementing solutions to achieve equity in Medicare quality*** may include the number and types of new tools, products, data, and other programs and initiatives that are developed, implemented, and disseminated to empower stakeholders to increase equity in Medicare quality for different priority populations.
- ***Measures for increasing actions to achieve equity in Medicare quality*** may include the number of providers and organizations (including QIN-QIOs) participating or collaborating in health equity activities; the implementation of new programs; and the utilization of new tools, data, and products by different stakeholders.

Activity-level Monitoring and Evaluation. At the activity level, we will conduct monitoring and process evaluations to assess the implementation of the activities. We will identify, establish, and track specific measurable milestones and performance metrics for each activity. This will enable us to ensure progress is being made on each activity and quickly identify when a mid-course correction is needed. Further, we will establish a baseline for activities that will be drawn from existing data sets and as well as newly created data. We will conduct process evaluations for all activities, and outcome evaluations for activities when possible. Process evaluations will explore whether activities are implemented as planned and have made progress towards achieving the goals of the six priority areas. We will utilize process measures to assess progress as well as any barriers. Outcome evaluations will assess the changes that have resulted from some of the activities. The evaluations will require extensive coordination and cooperation of the different stakeholders involved in the activities.

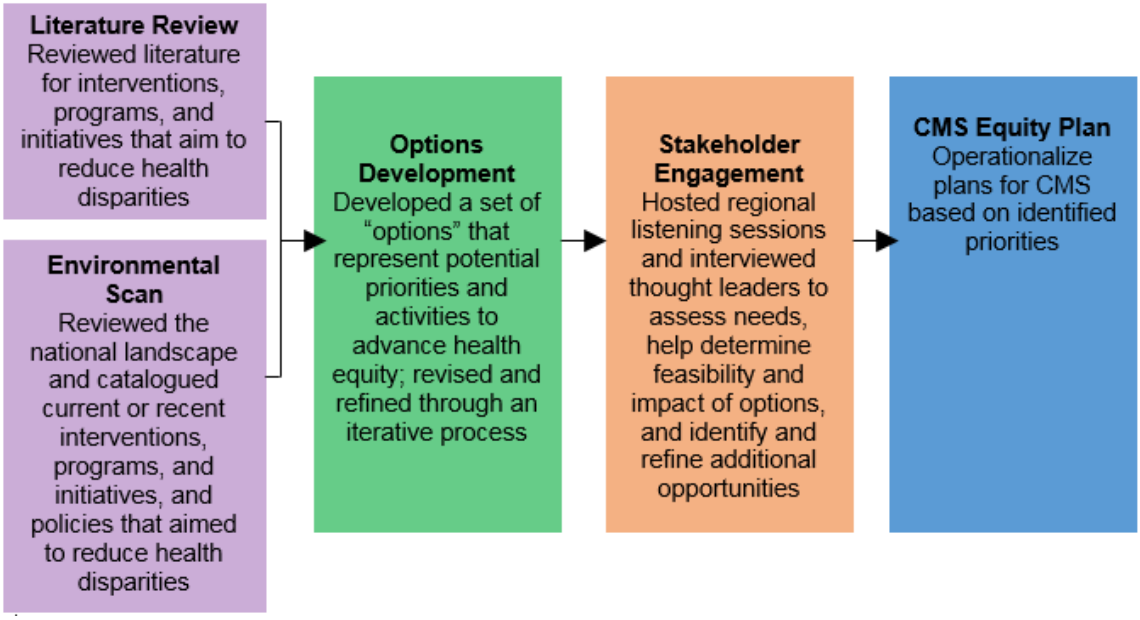
Finally, both levels of evaluation will incorporate opportunities for continuous quality improvement. We will use the Plan-Do-Study-Act framework to rapidly integrate learning generated through the priorities and activities, make changes when needed, and show improvements over time. This evaluation approach will help us to assess and document our progress toward achieving equity in Medicare quality through the *CMS Equity Plan for Medicare*.

Methodology

This section describes the process by which we developed the *CMS Equity Plan for Medicare*. First, we conducted a thorough literature review and environmental scan. The literature review identified evidence-based health care interventions, quality improvement programs, and initiatives in the gray and scientific literature with potential to reduce disparities among racial and ethnic minorities, sexual and gender minorities, and persons with disabilities. Likewise, the environmental scan identified promising health care interventions, programs, and initiatives, as well as policies stemming from the 2010 passage of the ACA. Next, we developed a set of "options," representing potential actions CMS could take to reduce health disparities. We refined these options with input from stakeholders in a series of regional listening sessions across the

U.S., as well as interviews with national thought leaders. Exhibit 3 provides a flowchart of our process.

Exhibit 3: CMS Equity Plan for Medicare Development Methodology Flowchart



We gathered input from a variety of stakeholders to ensure that the identified options were meaningful and would make an impact. We engaged with visionaries and thought leaders in health equity, as well as experts in CMS programs and levers. We sought their perspectives on:

- The most significant disparities in health care quality, and the drivers of those disparities;
- Barriers to implementing successful strategies to reduce disparities;
- Promising practices not yet reflected in the published literature;
- Opportunities for CMS to accelerate equity action; and
- Potential partners for CMS to advance this goal.

We collected stakeholder feedback through two main mechanisms: structured phone interviews with nationally renowned thought leaders and five listening sessions. We identified participants with a broad range of expertise and specifically included individuals who represent the perspectives of QIN-QIOs, as well as CMS and HHS regional office staff. By ensuring diversity among participants, we successfully gained input from an array of individuals with both a connection to health disparities work and knowledge of CMS programs. Stakeholder input supplemented findings from the literature review and environmental scan of what work has been implemented, what work is most likely to effect change, and how to effectively measure success. A total of 93 experts participated in these stakeholder engagement activities. **Exhibit 4** describes the participants' professional perspectives.

We asked stakeholders to rate, rank, and discuss options based on their perspective of the options' potential impact on health disparities and their alignment with CMS priorities and levers. Further, we asked participants to suggest how the options could be refined to increase their impact on health equity, suggest which activities were of least impact and importance, and identify topics that were not addressed in the options presented to them.

Exhibit 4: Roles of Listening Session Participants

- QIN-QIO Staff
- Researchers
- Health Educators
- Health Care Providers
- Health Insurers
- Community Based Organization Representatives
- Hospital System Leadership
- CMS and HHS Regional Office Staff
- State, Local and Federal Health Officials
- Advocates & Organizations Representing Priority Populations
- Health Care Professional Organizations

Based on the collective stakeholder feedback, the project team identified six priority areas and several high-yield activities as the foundation of the *CMS Equity Plan for Medicare*.

Overview of *CMS Equity Plan for Medicare* Priorities

Over the past year, we developed a core set of quality improvement priorities that target the individual, interpersonal, organizational, community, and policy levels of the United States health system in order to achieve equity in Medicare quality. The six priorities described below were developed with significant input and feedback from national and regional stakeholders and reflect our guiding framework of **understanding and awareness**, **solutions,** and **actions**. They provide an integrated approach to build health equity into existing and new efforts by CMS and stakeholders.

PRIORITY 1: EXPAND THE COLLECTION, REPORTING, AND ANALYSIS OF STANDARDIZED DATA

Priority 1 focuses on increasing **understanding and awareness** of the value of collecting and analyzing standardized patient data, and developing **solutions** and tools for stakeholders to collect and analyze local data and pinpoint needs and health disparities in their communities.

A growing body of literature suggests that increasing the collection of standardized demographic and language data across health care systems is an important first step towards improving population health.[ii] Comprehensive patient data, including race, ethnicity, language, sexual orientation, gender identity, and disability status are required to plan for quality improvements, and to address changes among the target populations over time. The ACA requires that federally funded health care and public health programs, as well as government surveys and

other activities, collect data on race, ethnicity, and preferred language. Developments in health information technology have significantly increased the feasibility of measuring disparities at the provider level as well as the capacity to do so.[iii] Further, the need for complete and accurate demographic data is being promoted more widely within the provider community, encouraged by federal guidance and meaningful use incentives.[iv]

Though research has identified evidence-based guidelines and practices for improving the collection of data on race, ethnicity, language, and disability status in health care settings, these guidelines are often not readily available to health care providers and staff. Preliminary research has been conducted to determine best practices for collecting sexual orientation and gender identity information in some populations, but currently there are no evidence-based guidelines to standardize this collection.

Example Activity:
Mapping Medicare Disparities Tool

This mapping tool identifies areas of large disparities in chronic diseases between racial and ethnic groups. It presents various chronic disease-related measures by state, county, age, gender, and Medicare-Medicaid dual eligibility status. The tool presents descriptive statistics on a dynamic, publicly available Web interface.

We will facilitate quality improvement efforts by disseminating best practices for the collection, reporting, and analysis of standardized data on race, ethnicity, language, sexual orientation, gender identity, and disability status so that stakeholders are able to identify and address the specific needs of their target audience(s) and monitor health disparities. Through enhanced data collection, reporting, and analysis, resources can be better allocated to meet needs.

PRIORITY 2: EVALUATE DISPARITIES IMPACTS AND INTEGRATE EQUITY SOLUTIONS ACROSS CMS PROGRAMS

Priority 2 focuses on increasing **understanding** of the impact CMS programs have on health disparities and on identifying, developing, and integrating proven **solutions** to improve their impact on vulnerable populations.

The ACA and related reforms created new opportunities to advance health equity through federal infrastructure, data collection, quality improvement, and research.[v] CMS programs foster the health and well-being of millions of Americans, making the agency a critical engine for these far-reaching reforms. Several CMS programs, including the QIO program's 11th (current) scope of work and the CMS Quality Strategy, have incorporated health equity as a goal or foundational principle, recognizing the critical role health equity plays in better care, better outcomes, and system savings. According to the HHS Disparities Action Plan, creating objectives for health care programs that contribute to the reduction of health disparities will shift the balance from addressing health issues in silos to creating population-wide health improvements for communities experiencing health disparities.[vi] However, CMS has not yet established a consistent way to assess its programs' impact on health equity.

We will work across CMS and with our stakeholders to understand the impact of existing programs on vulnerable Medicare populations and to ensure that new programs do not make

disparities worse. Further, we will identify best practices for reducing disparities and integrate these practices into CMS programs to promote equity. As we develop tools that work, we will spread them across the enterprise, making these solutions available to existing and new CMS programs so they may improve their own impact on health equity.

Example Activity: Disparities Impact Statements

Disparities Impact Statements can be used to ensure that vulnerable populations are included in pilot programs, and that disparities are not worsened as a result of new initiatives. Federal agencies including the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration currently use these tools to monitor programs' impact on health disparities.

Working across the agency to integrate proven solutions into CMS programs creates a framework for us to work with programs, grantees, and other partners to systematically increase equity in Medicare quality and reduce health disparities.

PRIORITY 3: DEVELOP AND DISSEMINATE PROMISING APPROACHES TO REDUCE HEALTH DISPARITIES

Priority 3 uses CMS' role as an incubator of innovation in health care delivery and payment models to develop promising **solutions** for improving equity in Medicare quality, and to foster **actions** to replicate and adapt effective models and strategies. We will focus on expanding promising approaches to reduce disparities, with CMS priorities in mind. National and regional stakeholders discussed the need for more guidance in 1) how to reduce readmissions among vulnerable persons with multiple chronic conditions such as diabetes or cardiovascular disease, and 2) how to improve the quality of nursing home care experienced by racial and ethnic minorities, sexual and gender minorities, and persons with disabilities.

Example Activity: Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries

This guide identifies key themes that emerge when devising a system to prevent hospital readmissions. It provides an overview of key issues related to readmissions for racially and ethnically diverse Medicare beneficiaries and a set of activities that can help hospital leaders take action to address readmissions in this population.

The Medicare Coordinated Care Demonstration's findings illustrate that hospital admissions and readmissions for chronic illnesses generate significant expenditures for Medicare.[vii] It is not clear if racial and ethnic minorities, sexual and gender minorities, and persons with disabilities are disproportionately represented in readmissions, but there is clear data showing that these groups are disproportionately affected by mental health concerns and comorbid chronic conditions.[viii,ix,x] Tailored approaches to care coordination can help to reduce disparities among these vulnerable populations.[xi] We will address this issue by developing and testing approaches to improve post-hospital discharge care coordination for priority populations (racial and ethnic minorities, sexual and gender minorities, and persons with disabilities) who also have a mental health diagnosis and other chronic conditions.

Another topic of concern to CMS is increasing the provision of culturally competent care in nursing homes. Nursing homes serve vulnerable and culturally diverse populations including racial and ethnic minorities, sexual and gender minorities, and persons with disabilities. Training in cultural competency, related to race, ethnicity, language, disability, sexual orientation, and gender identity is critical for all members of the care team. Research has shown that sexual and gender minority elders experience discriminatory and culturally insensitive treatment in nursing homes and long-term care, causing stress for these individuals and their families.[xii,xiii] Within this priority, we would increase the provision of culturally competent care in nursing homes by testing and implementing the use of *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)* in nursing homes.

PRIORITY 4: INCREASE THE ABILITY OF THE HEALTH CARE WORKFORCE TO MEET THE NEEDS OF VULNERABLE POPULATIONS

Priority 4 focuses on increasing **understanding** of health care workforce innovations in reducing disparities, developing **solutions** to equip the health care workforce to provide culturally competent and effective care, and disseminating best practices to drive stakeholders to **actions** that drive improvements in health care workforce quality and impact.

The adequacy of the health care workforce is critical to the quality of care and health outcomes of Medicare beneficiaries. The ACA includes provisions to improve access and delivery of care to underserved populations by providing opportunities for targeted workforce development and expansion. These opportunities include the incorporation of reimbursement for and expanding roles of mid-level providers and the option to increase the role of community health workers in health care systems. In the regional listening sessions, stakeholders highlighted opportunities and challenges they experience as they try to expand and adapt their health care workforce to better engage individuals and families in patient-centered, competent care. Diversifying the workforce by expanding the roles for community health workers, a top priority for CMS stakeholders, would conform to the national *CLAS* standards. These standards also provide guidance on how providers can reduce disparities by improving their cultural competence, health literacy, and language access.

Example Activity:
Business Case for CHWs

This activity will establish a learning and action network to support organizations with CHW programs and standardized trainings, in order to evaluate the cost-effectiveness of CHWs and other staff.

Experts acknowledge the challenge of patient and family engagement in a new value-focused health paradigm. This challenge is particularly acute for hospitals as they work to account for social needs and link patients to wrap-around services. Redesigned health delivery needs to engage patients and families not only through physician interactions, but also with nurses, pharmacists, health educators, community health workers, and dieticians who are equipped to reach patients where they are and communicate effectively with them. Expanding care teams to include new roles, and providing skills and competency training can help providers to improve the health of diverse patient populations and communities.[xiv]

PRIORITY 5: IMPROVE COMMUNICATION AND LANGUAGE ACCESS FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY AND PERSONS WITH DISABILITIES

Priority 5 focuses on **understanding** and raising **awareness** of barriers to the provision of communication and language access services, and disseminating **solutions** to enable **action** from providers to overcome those barriers.

Effective health care communication is defined as "the successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood."[xv] Communication should take into account an individuals' social background, including preferred language, health literacy level, culture, and disability status. Effective communication results in informed shared decision making between providers, patients and their families, and higher quality of care and better health outcomes.[xvi]

Example Activity: Language Access

This activity will identify and disseminate best practices and promising approaches to help providers and health plans improve language access for beneficiaries.

This priority will address disparities related to persons with limited English proficiency and individuals with disabilities. Persons with limited English proficiency often struggle to communicate effectively in English because their primary language is not English.[xvii] Eight percent of Medicare beneficiaries are persons with limited English proficiency.[xviii] According to the 2010 U.S. Census, there are approximately 56.7 million people—18.7 percent of the population—in the U.S. with a disability. Disabilities that affect communication can include hearing, visual, and cognitive impairments. In 2011, 12 percent of Medicare beneficiaries and 41 percent of dual-eligible beneficiaries had a disability.[xix] Communication and language barriers are associated with decreased quality of care and clinical outcomes, longer hospital stays, and higher rates of readmission.

Evidence suggests that ensuring communication and language access services for patients is important to delivering high quality care for all populations.[xx] To improve equity in Medicare quality, we will identify language access needs among beneficiaries with limited English proficiency and persons with disabilities across different care settings, and disseminate best practices that CMS and stakeholders can employ to improve communication and increase language access for the increasingly diverse Medicare population.

PRIORITY 6: INCREASE PHYSICAL ACCESSIBILITY OF HEALTH CARE FACILITIES

Priority 6 focuses on **understanding** the current landscape of physical accessibility to health care facilities for Medicare beneficiaries, identifying **solutions** to increase physical accessibility of health care facilities, and encouraging **action** to make health care facilities more accessible to beneficiaries with physical disabilities.

Individuals with disabilities experience significant disparities in health status: they are less likely to obtain preventive services such as mammography or Pap testing and they are more likely to delay getting needed medical care.[xxi] The challenges that populations with disabilities face are exacerbated by a variety of social, economic, and environmental conditions. In many cases, this comes down to a lack of available or known settings where people with physical access challenges can get care.

Physical inaccessibility of hospitals and provider offices reduces access to care for people with disabilities.[xxii] Despite the passage of the Americans with Disabilities Act of 1990 (ADA), national data are not available on the accessibility of health care facilities and services, and many provider offices and services are inaccessible to people with disabilities.[xxiii] A recent study of sub-specialty practices in four cities in the U.S. found that 22 percent of practices reported being unable to accommodate a patient in a wheelchair due to accessibility limitations.[xxiv]

Example Activity: Physical Disability Accessibility

This activity involves conducting research and analysis to better understand the current landscape around physical accessibility and explore research questions related to improving physical accessibility in various health care settings, such as physician's offices, hospitals, and clinics.

Researchers and stakeholders have identified a need to better enforce provider accessibility requirements and compliance with the ADA, and to collect data from providers on accessibility issues. We will conduct research on the current landscape of physical accessibility to understand gaps in knowledge and identify effective strategies CMS and stakeholders can implement to address those gaps. As we learn about the challenges and identify solutions, we will engage stakeholders to improve care for individuals with disabilities and contribute to increased equity in Medicare quality.

CONCLUSION

CMS sees tremendous value in increasing health equity in Medicare. By improving our **understanding and awareness** of disparities, their causes and why they matter; creating and disseminating promising **solutions**; and implementing sustainable **actions**, we will reach our destination of reduced disparities and healthier Medicare beneficiaries. The deliberate and thoughtful process we undertook to develop this plan yielded a set of six priorities which capitalize on CMS' critical role in advancing health equity and leverage the agency's existing work, while also identifying new and high-value opportunities to expand our impact. The priorities are designed to evolve with the changing health care environment, and the activities developed for each priority will reflect ongoing monitoring of emerging issues in health equity and Medicare. This plan embraces CMS' mission to continuously drive quality improvement and health care excellence. Implementing the *CMS Equity Plan for Medicare*—with the support of CMS centers and offices, QIN-QIOs, HENs, and other stakeholders—will foster higher quality and more equitable health care for all Medicare beneficiaries.

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