ENSURING Safety & Quality

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

With a focus on better patient health outcomes, CMS is holding providers accountable for providing safe and effective care, while minimizing administrative burden to ensure clinicians can spend more time with patients.

- We are focused on ensuring beneficiaries are empowered to make decisions about their health care based on quality and cost information. To achieve that, we are moving our quality programs to more robustly measure value and to give consumers access to that information in a way that is understandable and actionable.
- We ensure safety by partnering with state agencies and accrediting organizations, who are responsible for ensuring that all facilities are meeting the minimum health and safety standards.
- We are taking a hard look at how we oversee these entities, and we're strengthening our oversight to make sure that they are held accountable for consistency and effectiveness in serving this vital public trust role, and to ensure more transparency for beneficiaries. We published a notice seeking public comments about potential conflicts of interests for accrediting organizations that serve a role in identifying quality issues for Medicare purposes and who also offer fee-based consultation services for these providers and suppliers.
- We focused Quality Improvement Organizations (QIOs) on opioid misuse and behavioral health, while also connecting providers through the QIO Community Coalitions to support better health outcomes for beneficiaries.
- We are incorporating the voices of both beneficiaries and providers as we unleash innovative tools, provide better public information, and modernize quality payment and improvement programs to meet the needs of beneficiaries for generations to come.

Our actions have delivered results

- Hospital Improvement and Innovation Networks working with 4,000 acute care hospitals across the nation have generated a 13 percent reduction in the number of Hospital Acquired Conditions between 2014 and 2017, based on preliminary 2017 data. This translates into 20,500 lives saved from harms avoided and a savings of $7.7 Billion to the health care system.
- In 2018 and 2019, we worked to reduce the burden of quality measure reporting by focusing on quality measures that are most meaningful to patients and clinicians, with an emphasis on health outcomes, efficiency, safety and prevention. Our burden reduction actions are projected to save 40 million hours, through 2021.
- In 2018, our Meaningful Measures Initiative eliminated 79 measures across quality payment programs in the hospital setting, inpatient psychiatric facilities, ambulatory surgery, cancer hospitals, and hospital outpatient departments, resulting in projected savings of $128 million and an anticipated reduction of 3.3 million burden hours.

- In 2018, we reduced the burden of reporting quality measures with a focus on reporting through electronic means and incentivizing the use of clinical registries in the Merit-based Incentive Program.
- In April 2019, CMS released information about a 5 part plan to making sure Americans have access to the highest-quality nursing home compare. We are accomplishing this through:
    - Strenghtening Oversight;
    - Enhancing Enforcement;
    - Increasing Transparency;
    - Improving Quality; and
    - Putting Patients over Paperwork