U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

*Achieving a Transformed and Modernized Health Care System for the 21st Century*

# CMS Strategic Action Plan

## 2006–2009

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

# Centers for Medicare & Medicaid Services

# Strategic Action Plan
# for
# 2006 - 2009

## "ACHIEVING A TRANSFORMED AND MODERNIZED HEALTH CARE SYSTEM FOR THE 21ST CENTURY"

October 16, 2006

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# A MESSAGE FROM THE ADMINISTRATOR

Dear Colleagues:

The work that you do at the Centers for Medicare & Medicaid Services is much more than the specific tasks you do everyday.

On the one hand, you are part of a federal agency that, with a budget of approximately $650 billion, has a significant share in one of the most critical functions of the United States government: assuring these dollars are used appropriately and effectively.

On the other hand, each of you comes to work shouldering an even greater responsibility…both in and outside of government. You are responsible for the health of more than 90 million seniors, families, people with limited incomes, and people with disabilities. The work that you do can mean whether—and how well—we as a nation meet America's health care needs. As public servants, your work has immeasurable impact on the life of every single beneficiary that CMS serves.

This Strategic Action Plan covering 2006 – 2009 comes to you at a critical time in public service.

It's a time to savor an unprecedented accomplishment, the successful implementation of prescription drug coverage, the most far-reaching benefit to be added to Medicare since the program began. It's a time to take pride in the tremendous programmatic changes in Medicare and Medicaid, all accomplished while providing continuous service to beneficiaries.

It's also a time when CMS is attempting to transform itself from the world's largest indemnity insurer to a genuine promoter of the public's health.

Our vision is a health care system that is fully in step with medical care in the 21st Century. Care that not only uses technological innovation to full advantage, but also uses advances in disease management and preventive care. Care that is safe. Care that is affordable. Care that keeps people healthy, that is right for every patient, every time. This vision covers much more than our work at CMS. This agency is the largest health care payer in the world. It's no exaggeration to say that the actions we take will determine the future of health care.

The Strategic Action Plan is the blueprint that will help us reach the vision. It is a clear-eyed look at how far we've come and where we need to go. It spells out the CMS role in achieving HHS priorities in health information technology; Medicare prescription drug coverage; Medicaid modernization; transforming the New Orleans Health System; emergency response and Commissioned Corps renewal; prevention; pandemic preparedness; Science-driven opportunity for Management of personal health through Affordable, Reliable, and Targeted (SMART) health care; and health transparency.

It lays out the motivating objectives that we will use to achieve these goals—a skilled, committed and highly-motivated workforce; accurate, predictable payment; high-value health care; confident, informed consumers; and collaborative partners.

The plan is not a comprehensive list of all of the many things we do. Rather, the objectives outlined by this plan provide direction for our work. They are familiar objectives. They come from

the hard work and initiative of the best minds in this agency—from the bottom up and from the top down. We are already using them to improve our support to the people we serve, but we can still do more. I hope you will take the time to familiarize yourself with the plan. In September, we will schedule opportunities for you to share your views on this plan. I hope you will share them.

As you take a look at the strategic plan, I hope you will see how the work you do as one individual CMS employee really matters, now more than ever. Your contribution makes a difference every day to an essential and increasingly important part of our federal government's responsibilities, and to many of the more than 90 million Americans who count on us at the most basic and personal level. With the CMS Strategic Action Plan, we are taking another key step in working together to create a smarter, more affordable health care system that offers the best in American health care to our beneficiaries, and to the country overall.

Sincerely,

Mark B. McClellan, MD, PhD

# CMS' Strategic Action Plan 2006 – 2009

*"Achieving a Transformed and Modernized Health Care System for the 21st Century"*

## EXECUTIVE SUMMARY

### Background

With a budget of approximately $650 billion and serving approximately 90 million beneficiaries, the Centers for Medicare & Medicaid Services (CMS) plays a key role in the overall direction of the health care system. CMS has an unparalleled opportunity to improve care and to make it more affordable for everyone.

**CMS' Mission:** To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.

**CMS' Vision:** To achieve a transformed and modernized health care system.

CMS will accomplish our mission by continuing to transform and modernize America's health care system.

CMS aims to expand its resources in a way that both improves health care quality and lowers costs. We will do this by being stewards accountable for resources and effectiveness. This Strategic Action Plan outlines how CMS will work toward achieving this mission.

This strategic direction can be described through five key objectives:

1. Skilled, Committed, and Highly-Motivated Workforce
2. Accurate and Predictable Payments
3. High-Value Health Care
4. Confident, Informed Consumers
5. Collaborative Partnerships

### CMS' Strategic Action Plan Objectives

1. **Skilled, Committed, and Highly-Motivated Workforce**
    - CMS will have the right people with the right expertise in the right positions to help deliver the Strategic Action Plan to accomplish the agency's mission.
    - CMS senior management will assure its workforce is resilient, competent, diverse, flexible, and motivated to accomplish the mission.
    - CMS will complete and implement the Human Capital Management plan and the CMS Succession process and plan.
    - To make sure that the daily work of CMS reflects the goals in this plan, CMS will establish Enterprise Portfolio Management. This system will inventory all CMS projects and assign resources. Doing this helps senior leadership prioritize employee workload.

2. **Accurate and Predictable Payments**
    - CMS will effectively oversee its providers and aggressively deliver provider education and outreach. Doing so will help us achieve strong financial performance for our programs and operations. Oversight will include expanded, modernized program

integrity for Medicare and Medicaid and ways to prevent overpayments and improper payments.

- These modernization objectives will better facilitate CMS preparedness in emergencies and pandemic planning.
- By developing strategies for transparency and value incentives for consumers and providers, CMS may improve the long-range sustainability of CMS programs and reduce costs and improve long-range solvency for Medicare.
- Additional modernization initiatives include implementing a Health Care Integrated General Ledger Accounting System and a National Provider Identifier; transitioning the legacy system of Intermediaries and Carriers to the Medicare Administrative Contractor system; increasing electronic claims processing using upgraded Information Technology systems; and reforming the Prospective Payment Systems.
- CMS will refine the process of validating payments made to Medicare Advantage organizations, Prescriptions Drug Plans and other organizations paid through the Medicare Advantage Prescription Drug System (MARx).

**3. High-Value Health Care**

- CMS must support the transformation of the health care system to one in which patients and doctors can make informed decisions together about the most effective medical care, based on timely access to the latest evidence, and in a way that delivers the highest value care.
- This transformed system will include SMART health care (**S**cience-driven opportunity for **M**anagement of personal health through **A**ffordable, **R**eliable, and **T**argeted care); secure electronic records; e-prescribing; transparency based on immediate, accurate and comparative quality and cost information; new Medicare Advantage plan designs and innovative prescription plan approaches, disease management programs, disease prevention; and value-based payment. As part of this transformed system, CMS will stay committed to protecting the security and privacy of our beneficiaries' health care data.
- To achieve this transformation, we will expand quality and cost measurement in Medicare fee-for-service systems; emphasize prevention and better support for quality care; implement pay-for-performance to promote better quality and more efficient care; enhance long-term solvency; encourage Medicaid reform; help redesign the New Orleans Health System; establish an integrated data repository; and modernize IT capabilities.
- Developing new Medicare Advantage plan types, such as dual eligible and chronic care special needs plans, to improve overall cost and quality outcomes for high risk populations and increase integration and coordination with state Medicaid Programs for dually eligible Medicare beneficiaries
- Supporting drug plan sponsors in their efforts to improve care coordination and to develop innovative approaches to improving the quality of care for our beneficiaries.

**4. Confident, Informed Consumers**

- To create a successful personalized health care system, we will make sure that everyone with Medicare makes the most of their Medicare benefits.
- We will use our personalized tools and our well-developed grassroots network of partners to develop direct relationships with beneficiaries.
- Consumers will participate in SMART health care and have immediate access to affordable Medicare prescription drugs, transparency based on comparative quality and

cost information, flexible Medicaid benefits and incentives, and access to care in homes and communities for the disabled population.
- CMS will get beneficiaries the best quality care for the best price by developing ways to let them know their medical options before they need treatment, the quality and expertise of doctors and hospitals in their area, and how much their medical care will cost them.

**5. Collaborative Partnerships**

- Personalized, modern health care is a complex network of various providers surrounding the person who needs care. To make this work, we need collaborative partnerships that all work toward getting the beneficiary quality care information.
- The success of CMS depends on collaborative relationships with a variety of organizations, individuals and institutions.
- CMS will restructure and expand its external affairs and communications activities to allow us to have well-established interactions with outside groups.
- CMS Regional Offices will continue as primary resources in planning and implementing agency outreach initiatives, and in conducting environmental scanning to identify impacts on our customers.
- We will also continue to develop health and grassroots networks for Medicare and Medicaid, and establish ties with quality alliances and local communities to support getting better health care. In addition, we will seek ways to work with other large health insurers in the U.S. system, both government and private-sector, to share ideas to improve the quality and delivery of health care and health care information.
- With effective collaboration, CMS will create and sustain a better environment for high-quality, personalized care for every person, every time.
- CMS will continue to pursue relationships with provider groups at the national and local level and use these relationships to reach the individual provider with important program and initiative information.
- Improve beneficiary choices and awareness of Medicare managed care products and prescription drug coverage by working with our private sector health plan and prescription drug plan partners, various industry and trade groups and beneficiary organizations.

# CMS' MISSION

**To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries.**

# CMS' VISION

**To achieve a transformed and modernized health care system.**

CMS will continue its efforts to meet its mission by striving to achieve the vision of a transformed and modernized health care system for America. Using this Strategic Action Plan as our roadmap, we will strengthen our workforce to manage and implement our programs, make sure those who provide health care services are paid the right amount at the right time, work toward a high-value health care system, make our consumers confident by giving them more information, and continue to develop Collaborative Partnerships.

# INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) is an agency within the Department of Health and Human Services (HHS). Created in 1977, CMS brought together the two largest Federal health care programs, Medicare and Medicaid under a unified leadership. In 1997, the State Children's Health Insurance Program (SCHIP) was established to address the health care needs of uninsured children. With a current budget of over $650 billion and serving approximately 90 million beneficiaries, CMS has become the largest purchaser of health care in the United States.

CMS accomplishes its mission through the efforts of over 4,800 employees and many partners. CMS employees are located in Central Office as well as 10 Regional Offices throughout the country. Our partners include contractors, States, territories, tribes, health care professionals and providers, health care groups and associates, beneficiary and consumer organizations, accrediting bodies, and researchers. We continually examine and renew our definition of partnership to allow for meaningful two-way exchange and true collaboration for all CMS programs and special HHS initiatives, such as the New Orleans Health System. Thanks to our employees and partners, CMS has been able to accomplish tremendous programmatic changes in Medicare and Medicaid, all while providing continuous service to our beneficiaries.

In 2003, the Medicare Modernization Act (MMA) provided extraordinary changes to the Medicare program, including creating the prescription drug benefit (Medicare Part D) and the Medicare Advantage option. In 2006, we achieved a phenomenally successful roll-out of the largest expansion of Medicare in 40 years, with over 38 million beneficiaries with prescription drug coverage. We are committed to continuous quality improvement to make Medicare Part D even better. We will work to do this through streamlined and better choices for beneficiaries; willing participation by plans; improved relationships with States and pharmacists; increased use of electronic technology to streamline benefit delivery; and continued outreach and education to ensure that our beneficiaries and partners understand our programs.

The demographic changes that will occur as the post-World War II Baby Boomers age are well known. The impact of the retirement of the Baby Boomers, together with declining birth rates and

continuing improvements to health care that extend life expectancy means we will have more older persons than working-age people, beginning in 2010. Currently, there are 3.9 workers for each person with Medicare. By 2030, when all of the Baby Boomers are eligible for Medicare, there will be only 2.4 workers for each beneficiary. The expected drop in the ratio of active workers to retirees is one of the reasons people project that Medicare Part A payroll tax revenues won't keep pace with expected Part A expenditures. Also, as the number of elderly beneficiaries increases, they may need long-term care. This will affect Medicaid, in part because Medicaid covers long-term care services. CMS will work to improve the long-term sustainability of our programs. We will develop strategies for price and quality transparency and "value incentives" for consumers and providers. Many of these strategies will be supported by our research and demonstration programs. In doing this, we will fulfill our fiduciary responsibility.

In 2006, Congress passed the Deficit Reduction Act (DRA) to help sustain Medicare and Medicaid. The DRA requires CMS to ensure that Medicare and Medicaid beneficiaries continue to have access to high-quality medical care in the most appropriate setting. We are making progress toward addressing long-term solvency while providing better care and sustainable coverage. We're doing this by adopting Health Information Technology, increasing the focus on prevention, and creating more transparency in our programs. We are developing better information on quality and costs of health care, and we are starting to pay more for quality care to ensure our beneficiaries get the best care at the lowest possible cost.

Sparked by the passage of the DRA, CMS is also on the cusp of redefining and modernizing the Medicaid program. Medicaid now has tremendous potential to give beneficiaries more choice, as the States have many new options for delivering benefits beyond basic services to consumers. A key part of Medicaid reform is to provide up-to-date benefit choices and to support consumers in making the best choices for them. Medicaid reform also includes a focus on reforming long-term care options and increased integrity efforts. Over the next three years, CMS will continue to work with our partners to redefine and modernize Medicaid.

Our Strategic Action Plan through 2009 describes our plans and how we will measure performance. While our mission and vision remain largely unchanged, this CMS Strategic Action Plan supports the HHS Priorities for America's Health Care and is captured under five CMS Strategic Objectives. The following chart describes the link between the HHS Priorities and the CMS Strategic Objectives.

| HHS Priorities - CMS Objectives Link | | | | | |
|---|---|---|---|---|---|
| | CMS Strategic Action Plan Objectives | | | | |
| HHS Priorities | 1. Skilled, Committed, and Highly-motivated Workforce | 2. Accurate and Predictable Payments | 3. High-value Health Care | 4. Confident, Informed Consumers | 5. Collaborative Partnerships |
| Health Information Technology | X | X | X | X | X |
| Medicare Rx | X | X | X | X | X |
| Medicaid Modernization | X | X | X | X | X |
| New Orleans Health System | X | X | X | X | X |
| Emergency Response and Commissioned Corps Renewal | X | X | | | X |
| Prevention | X | | X | X | X |
| Pandemic Preparedness | X | X | | X | X |
| SMART Health Care | X | | X | X | X |
| Health Transparency | X | X | X | X | X |

## Health Information Technology

*HHS Priority: The medical clipboard becomes a thing of the past. Secure, interoperable electronic records are available to patients and their doctors anytime, anywhere. Immediate access to accurate information reduces dangerous medical errors and helps control health care costs. This, in turn, establishes standards and ensures efficient collection of quality information.*

CMS IT modernization efforts are part of the Health Information Technology Framework. We have accelerated many of our IT modernization projects already under way, as well as developed IT solutions for new business requirements. Adopting this technology will also enhance safety and minimize the resources required for reporting quality measures. We are on track to finalize widely adoptable e-prescribing standards. The use of Electronic Data Interchange (EDI) transactions will allow providers to submit secure claims transactions faster, to be paid for claims faster, and to accomplish this at a lower cost and more accurately than is generally the case for paper or manual transactions.

## Medicare Rx

*HHS Priority: Every senior has access to affordable prescription drugs. Consumers will inspire plans to provide better benefits at lower cost. Medicare Part D is streamlined and improved to better connect people with their benefits.*

Medicare Rx is the continuation of a phenomenally successful roll-out of the largest expansion of Medicare in 40 years. CMS worked with its many partners to educate millions of seniors about this benefit, which is saving beneficiaries money on their prescription drugs. We are continuing to

make Medicare Part D even better with streamlined and better choices for beneficiaries, willing participation by plans, and improved relationships with States and pharmacists. In addition, we will continue to harness the power of electronic technology to streamline benefit delivery and to provide continued strong messaging to our consumers.

## Medicaid Modernization

*HHS Priority: Sustainable Medicaid programs provide coverage for millions of people who are not covered now. People in differing economic situations are helped through flexible benefits and incentives tailored to meet their needs. People with disabilities have access to care in their homes and communities. CMS is Modernizing Medicaid with the States by embracing increased benefit flexibility of State Plan options as authorized by the Deficit Reduction Act.*

CMS is working with its partners to explore innovative ways to make the Medicaid program more sustainable over time. The DRA has helped us move in that direction by mandating this reform and giving CMS the flexibilities needed to accomplish its goals. CMS will provide clear direction on its policies to help all states use the new benefit flexibility options to realize Medicaid innovation and efficiencies, while creating programs tailored to meet the needs of diverse populations through Medicaid State Plan Amendments. We will expeditiously review and approve benefit flexibility State Plan Amendments. We will increase flexibility options to states by identifying how states may begin the process of incorporating Health Opportunity Accounts into the Medicaid programs. Other Medicaid modernization activities will include increasing the number of individuals transitioned from institutions to communities, implementing Long-Term Care Reform (a joint Medicare-Medicaid focus), promoting private long-term care insurance coverage, and working with states to give Medicaid beneficiaries access to modern health insurance products without waivers.

The DRA created the Medicaid Integrity Program (MIP) which dramatically increases both CMS' obligations and resources to combat fraud and abuse. In FY 2006, $5 million has been appropriated with an additional $50 million in each of FYs 2007 & 2008 and $75 million in FY 2009 and each year thereafter. In addition, DRA requires CMS to hire 100 new FTEs "whose duties consist solely of protecting the integrity of the Medicaid program." Successful implementation will require a high degree of coordination among the states, CMS Central and Regional offices and with Medicare Program Integrity (PI).

## New Orleans Health System

*HHS Priority: Adversity turns to advantage. The New Orleans Health System of antiquated, inefficient emergency room care becomes a place where every citizen has a medical home that is prevention-centered, neighborhood-located and electronically-connected. The vision is to provide a highly-functioning, sustainable health infrastructure that is capable of providing high-quality care, in the right setting, when needed. This priority has the potential to serve as a model for the nation.*

CMS is developing a redesign project with the goal of producing an appropriate, comprehensive, system-wide Medicaid waiver and Medicare demonstration proposal to accomplish the vision for the Greater New Orleans area. We are actively developing direct relationships with beneficiaries through personalized tools and our well-developed grassroots network of partners. To this end, we will restructure and expand external affairs and communication activities to create well-established interactions with outside groups. This will allow us to further our quality alliances and ongoing campaign activities.

## Emergency Response and Commissioned Corps Renewal

*HHS Priority: We have learned from the past and are better prepared for the future. There is an ethic of preparedness at HHS and throughout our Nation. We have a Commissioned Corps that is bigger, better trained, and deployable.*

CMS is developing model emergency plans and policies to help providers prepare for, evacuate, and shelter in an emergency. Furthermore, we are developing policies and guidance that improve the survey process to stimulate effective health care provider emergency preparedness. To ensure the agency's preparedness, CMS continues to maintain and improve its Continuity of Operations Plan, under which we will continue to provide services during disasters. CMS' expanded and modernized program integrity efforts for Medicare and Medicaid will better prepare CMS to respond to emergencies and plan for pandemics.

## Prevention

*HHS Priority: The risk of many diseases and health conditions is reduced through preventive actions. A culture of wellness deters or diminishes debilitating and costly health events. Individual health care is built on a foundation of responsibility for personal wellness.*

CMS is increasing its focus on prevention through several initiatives. We are expanding Medicare preventive screenings, aggressively educating health care providers about preventive benefits, leveraging the preventive power of the drug benefit, taking advantage of prevention opportunities for racial and ethnic minorities, reaching out to states to increase preventive service use, and providing evidence-based clinical recommendations to providers. We will develop a quality initiative to demonstrate benefits of Part D on secondary and tertiary prevention. We will also measure the correlation of using Part D benefits with avoiding unnecessary hospitalizations. In addition, we have launched a value-based purchasing system for our hospital and physician settings, such as the hospital pay-for-reporting and the physician voluntary reporting programs, which will include preventive services measures. As part of our Doctor Office Quality IT (DOQ-IT) Initiative, we are collecting preventive and other health quality measures electronically via Electronic Health Records (EHRs).

## Pandemic Preparedness

*HHS Priority: The United States is better prepared for an influenza pandemic. Rapid vaccine production capacity is increased, national stockpiles and distribution systems are in place, disease monitoring and communication systems are expanded and local preparedness has been dramatically enhanced. Planning and preparedness encompasses all levels of government and society.*

CMS developed an operational plan for our participation in the Department's preparation and response to an influenza pandemic. We will coordinate with other HHS Operating Divisions (OpDivs), Staff Divisions, and the Office of the Secretary to ensure that the Department's response to a pandemic is as seamless as possible, and that CMS activities support the initiatives of other OpDivs. We will implement pandemic-specific initiatives to promote access to quality health care during the pandemic and its aftermath, and will maintain existing programmatic operations to ensure beneficiary access to services and prompt, accurate payment for the providers of those services.

## Personalized - SMART Health Care

*HHS Priority: Personalized Health Care: Health care is tailored to the individual. Prevention is emphasized. Propensities for disease are identified and addressed through preemptive*

*intervention. Discovery and innovation move new medical devices and drugs to the market and to medical practice faster and at lower cost.*

SMART Health Care is Science-driven opportunity for Management of personal health through Affordable, Reliable, and Targeted care. CMS supports this HHS priority through its focus on high-value health care and empowering consumers to make quality and cost-effective health care choices. CMS will work with its partners to provide personalized care by supporting preventive health care options, quick access to new treatments, medical devices, and drugs, pay-for-performance activities, and the Personal Health Record initiative.

### Health Transparency

*HHS Priority: Health Transparency provides for consumers to have easy access to helpful comparative information regarding health care quality, patient experience, and health care cost to guide their health care decisions.*

To achieve transparency, we need motivated consumers and engaged providers who support using measures to improve quality. CMS is supporting this priority by developing quality alliances to obtain and disseminate consistent quality measures of health care, allowing consumers to make better informed choices. With these alliances in place, CMS will provide easy-to-access information about health care quality, patient experience, and pricing to consumers. We will include comparative information on providers and other key stakeholders including hospitals, ambulatory care centers, cancer and kidney care centers, pharmacies, and nursing homes. We are on track to establish demonstrations and pilots which include performance-based payments. The public reporting aspect of our various pay-for-performance initiatives will also generate data that can be used to support transparency. We are redesigning our Quality Improvement Organizations to provide technical support for implementing quality/cost measures and improving medical practice.

# CMS' STRATEGIC ACTION PLAN OBJECTIVES

## *1: SKILLED, COMMITTED, AND HIGHLY MOTIVATED WORKFORCE*

Attracting, developing, and retaining high-performing managers and employees are key for CMS to accomplish its many critical programs and the initiatives identified in this Plan. As a primary partner in shaping the future of America's health care, our goal is to make CMS the "employer of choice" for seasoned professionals and emerging leaders in the health care arena. CMS will maintain a highly-skilled, diverse workforce that is equipped to transform America's health care system. We will strive to provide state-of-the-art administrative technology and processes to enable employees to complete our important work with the least possible amount of administrative burden.

CMS' vision for human capital management calls for a strategically-aligned workforce that supports the CMS and HHS mission, responds effectively in emergencies, positions bench strength to assume leadership positions, and becomes a most efficient organization, with the "right" people in the "right" position at the "right" time. An implicit component of this strategy requires CMS to hire and retain a workforce that reflects the diversity of the populations that we serve. Doing so allows us to understand the needs of the populations we serve and effectively address them. CMS is committed to applying these principles for human capital management to ensure a workforce that is resilient, competent, diverse, flexible, and motivated to accomplish our mission.

Human capital initiatives through 2009 include:

**Human Capital Management Plan**

CMS faces a series of unprecedented internal business and external environmental challenges, which have major implications for the workforce and accomplishing the Agency's mission. These challenges include rapid and significant changes in health care delivery and related technology, CMS' emerging strategic role as an active health care market presence, and CMS' aging workforce and the increased competition for skilled workers.

CMS' *FY 2005 - 2008 Human Capital Management Plan* (HCMP) establishes a framework for developing an organizational structure that is citizen-centered, results-oriented and market-based. Our approach is strategic, dynamic, and aligned with the agency's current and future business needs. The HCM process will: (1) integrate recruitment policies and systems to allow us to identify and quickly hire highly-competent employees; (2) retain high-performing employees through innovative incentive structures; (3) reward CMS employees by linking performance awards to specific program performance goals; and (4) develop and refine organizational structures that are efficient and effective.

By FY 2008, 45 percent of CMS' managers and 28 percent of CMS' current workforce will be eligible to retire. This will create skill gaps in virtually all occupations within CMS. CMS must use various techniques to effectively manage human capital. For example, implementing employee development programs that cover all levels of the CMS workforce, significantly improving the agency's hiring practices, fully exercising recruitment and retention flexibilities and e-Gov solutions, and using competitive sourcing as a mechanism for closing skill gaps are some of the comprehensive strategies that are already under way and will continue beyond FY 2009.

Accordingly, we will support the HCMP by:

- Implementing the Extreme Hiring Makeover Project (EHM) throughout CMS. EHM provides a new approach to effective recruitment and hiring. It also helps us get the right people with the right skills in the right jobs at the right time. To do this, CMS will use the following strategies:
  - have strategic conversations with hiring managers to clearly define the competencies needed for each vacancy posting;
  - use competency assessments to recruit employees;
  - re-design our vacancy announcements to attract the best talent;
  - use a "Manager's Toolkit" to train managers on hiring; and
  - hold our managers and human resource professionals accountable for being stewards of CMS' valuable resources.
- Increasing the use of recruitment and retention flexibilities currently available, such as direct hire authority, recruitment and retention bonuses, superior qualifications appointment authority, and relocation bonuses;
- Using the Federal Career Intern, Emerging Leaders, Presidential Management Fellows Program, and the Senior Executive Service Career Development Programs to supplement the pool of quality talent who can move into leadership positions as they become available;
- Increasing workforce diversity, especially in mission-critical occupations, by using a variety of special appointment authorities and recruitment options, holding managers accountable for achieving results, enhancing ongoing relationships with minority organizations, and developing, implementing, and evaluating strategies for diversifying the workforce;
- Integrating our competitive sourcing activities into CMS' overall human capital management strategies (i.e. moving staff from support-type positions to mission-critical functions consistent with our competitive sourcing program);
- Eliminating competency gaps in our most critical occupations by identifying proficiency gaps and proficiency levels for each Mission Critical Occupation (MCO), implementing core competency models for all MCOs, and developing and implementing plans for closing the gaps in all MCOs by the end of FY 2007;
- Implementing new Performance Management Appraisal Program (PMAP) that provides meaningful measurement of individual performance and provides information for making informed decisions about awards and recognition, training, reassignment/re-deployment potential, functional assignments, and retention;
- Providing enhanced employee development programs and training options linked to individual employee development plans; and
- Growing leaders by delivering or identifying leadership development programs that enable employees and managers to demonstrate CMS' five core leadership competencies of Managing Change, Leading People, Managing Resources, Producing Results, and Building Partnerships and Coalitions.

### CMS Succession Plan

In the fall, 2005, CMS initiated an agency-wide succession planning system to help us identify both the talent pool in our employees and key roles that are potentially at risk due to attrition.
In FY 2005, CMS conducted an inventory of its management and senior technical ranks. That study revealed the potential for a significant increase in attrition in key leadership positions over the next five to 10 years. The primary cause for the projected increase is the approaching retirement eligibility of 45 percent of CMS' incumbent staff in grades GS-14 and above. To accomplish our mission, CMS needs leadership with extensive program knowledge, high-level technical/professional expertise, and effective management and leadership skills. Among its first

benefits, the Succession Management System will provide the long-range overview necessary to help management determine the most effective way to plan for the succession in the next decade.

CMS is moving forward to implement this process.

- By the end of FY 2006, the CMS Succession Plan will encompass more than 1100 leadership roles and incumbent staff ranging from the SES management ranks through senior technical experts in every major occupational category.
- In FY 2007 CMS will create a flexible and automated Succession Management System, which will be the driver for our recruitment and retention, employee development, management development, and diversity recruitment plans.

**Automation to Support Employee Work**

CMS is automating a variety of internal administrative processes in order to support managers and staff who are accountable for effectively developing and executing CMS' many complex initiatives. In 2007-2008, Enterprise Portfolio Management (EPM) will serve as the bridge between the Strategic Action Plan and day-to-day CMS work. The Priority Project Tracker (PPT) System, a performance-based EPM system, will effectively manage the work performed at CMS. The system tracks and reports information on projects to support the CMS Organizational Assessment and crosswalks projects with the "HHS Top 20," the Secretary's 500 day plan, and the President's Management Agenda. Furthermore, the projects that are managed in PPT support our Strategic Action Plan, SES performance plans, and on-going day-to-day operations.

We will continue to develop and mature our EPM System by:

- Establishing an inventory of all CMS projects;
- Developing an enterprise portfolio structure that consists of business functions and lines of business; and
- Assigning resources (FTEs, budget) and other relevant information to the projects/portfolios, which will enable senior leadership to make informed decisions in prioritizing workload from an agency-wide perspective.

The remainder of the objectives in this Plan relies on our ability to manage and leverage a skilled, committed, and highly-motivated workforce.

## *2: ACCURATE AND PREDICTABLE PAYMENTS*

CMS must make sure that the more than $650 billion we make in payments each year is accurate and timely. By developing and executing effective oversight and aggressive provider education and outreach, CMS can achieve strong financial performance for its programs and operations. Oversight will include expanded modernized program integrity for Medicare and Medicaid and preventing improper payments. The modernization programs will better facilitate CMS' preparedness and response in emergencies and planning for a pandemic. Finally, CMS' strategies for cost and quality transparency and "value incentives" for consumers have the potential to help reduce costs, which would improve both long-term sustainability and solvency for our programs.

In addition to strengthening the Medicare Integrity Program to encompass the new prescription drug benefit and Medicare Advantage plans, CMS is also improving Medicaid integrity through the new Medicaid Integrity Program. Several modernization initiatives currently under way will support efforts to strengthen CMS' financial management and program integrity. Implementing IT

systems and process reform, such as Health Care Integrated General Ledger Accounting System (HIGLAS), ICD-10, upgraded electronic claims processing, and reforming the Prospective Payment Systems will strengthen financial management of the Medicare Program. Also, part of the New Orleans Health System initiative will support accurate and predictable payments. These systems and structural changes will allow more effective financial oversight and reporting of the programs, and will result in lower error rates and improper payments.

Two ways that we are supporting accurate and predictable Medicare payments are expanding the Performance Assessment of Medicare Advantage plans to include Part D plans and managing Medicare Secondary Payer (MSP) recoveries. We're also focused on Medicaid payments by processing and overseeing Federal Medicaid grants and demonstrations, which reimburse states a percentage of their expenditures in providing health care for individuals whose income and resources fall below specified levels.

Accurate and Predictable Payment initiatives through 2009 include:

**Measuring and Reducing Payment Errors through Improper Payments Information Act (IPIA) Compliance**

CMS is working diligently to measure and reduce improper payments in our programs and to comply with the Improper Payments Information Act of 2002 (IPIA). Since FY 2003, CMS has reported a Medicare fee-for-service error rate as part of our Comprehensive Error Rate Testing (CERT) program and Hospital Payment Monitoring Program. Over the past several years, CMS proactively tested the methods to estimate improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) through Payment Accuracy Measurement (PAM) and Payment Error Rate Measurement pilots. These pilot projects led to the development of a national program called Payment Error Rate Measurement (PERM) to measure improper payments in Medicaid and SCHIP.

CMS is working to achieve compliance with the IPIA and reduce improper payments by:

- Reducing the Medicare fee-for-service claims payment error rate to 4.7 percent by the end of FY 2008;
- Continuing to support a comprehensive provider education and outreach program so that providers know the rules and can bill appropriately;
- Reporting error rates for Medicaid and SCHIP for FY 2007 in the FY 2008 Performance and Accountability Report (PAR); and
- Completing the Risk Assessments for Medicare Advantage and Part D and finalizing our measurement strategies and reporting schedule.

**Expanding a Data-Driven Approach to the Medicare Integrity Program (Medicare MIP)**

The Medicare Integrity Program (MIP) established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided CMS with dedicated funding to identify and combat improper payments and fraud and abuse. CMS uses MIP funds to support program integrity contractor performance of the following activities: audits of cost reports, medical review of claims, identification of potential fraud cases, and education to inform providers about appropriate billing procedures. As required by statute, MIP funding rose from $440 million in FY1997 to a steady rate of $720 million since FY2003. In addition, the Deficit Reduction Act of 2005 (DRA) provided additional funding for this activity in FY2006.

We continually review our Medicare program integrity activities to make sure we're using our resources effectively and performing well. Based on our experience gained from the Medicare

MIP, CMS has moved ahead with efforts to expand and strengthen our work to protect the Medicare Trust Funds; increase our oversight capacity; and focus more on identifying, responding and resolving problems. CMS recently expanded our program integrity oversight to include the new Medicare prescription drug benefit (Part D) and the Medicare Advantage plans. We contracted with Medicare Drug Integrity Contractors (MEDICS) to support CMS' anti-fraud and abuse efforts associated with Part D. CMS is also expanding the use of electronic data to more efficiently detect improper payments and program vulnerabilities.

CMS will continue the expansion of the Medicare Integrity Program by:

- Implementing the Medicare Drug Integrity Contractor (MEDICS) contracting strategy to find trends that may indicate fraud and abuse, investigate potential fraudulent activities, conduct fraud complaint investigations and refer cases to the appropriate law enforcement agency as needed;
- Developing and validating new and existing methods to detect and prevent abusive use of services, as well as possible fraud and abuse schemes;
- Leveraging CMS data systems and repositories to implement the One Program Integrity (One PI) System Integrator and modernizing our data analysis capability for program integrity efforts. Medicaid and Medicare Part D data are the initial focuses of the One PI System Integrator.
- Continuing the evolution of the Program Safeguard Contractors (PSCs) toward a more outcome-oriented and performance-based approach in identifying and combating fraud and abuse;
- Expanding the Medicare/Medicaid ("Medi-Medi") data match programs beyond the current 10 states with the funding outlined in the Deficit Reduction Act. These projects use fraud and abuse mining tools to query across data from both programs to detect fraudulent patterns that may not be evident when billings for either program are viewed in isolation;
- Redesigning CMS audit processes and desk review programs by using payment and savings data analysis to focus audit activities. Our efforts will be targeted to areas of higher risk; and
- Continuing to consolidate the activities at the Coordination of Benefits Contractor (COBC) and our use of Voluntary Data Sharing Agreements (VDSAs) with employers and insurers to enhance the way we manage beneficiaries' insurance coverage information.

### Implementing the Medicaid Integrity Program (Medicaid MIP)

The Medicaid Integrity Program (MIP), created through the Deficit Reduction Act (DRA) of 2005, dramatically increases both CMS' obligations and resources to combat fraud and abuse. Five million dollars has been appropriated in FY2006, with an additional $50 million in each of FY07 and 08, and $75 million annually in FY09 and each year thereafter. The DRA mandated CMS to hire 100 new employees, whose duties will consist solely of protecting the integrity of the Medicaid program.

By 2009, CMS will fully implement the Medicaid Integrity Program by:

- Creating a comprehensive integrity plan, in consultation with internal and external partners;
- Procuring and overseeing Medicaid Integrity Contractors (MICs) who will conduct reviews, audits, and education;
- Developing field operations to provide State program integrity oversight reviews and support in the form of technical assistance and fraud and abuse training; and
- Developing fraud research and detection activities to provide statistical and data support, identifying emerging fraud trends and conducting special studies as appropriate.

### Enhancing CMS' Financial Management Systems--HIGLAS

CMS is replacing its legacy Medicare accounting systems, maintained by both CMS and its current Medicare FFS contractors, with the new HIGLAS – a State-of-the art electronic, integrated financial accounting system. Full implementation of HIGLAS by 2011 will allow CMS to track Medicare payments. It will also allow us to accurately pay claims for over 43 million Medicare beneficiaries (the FY07 count), and will strengthen the overall financial management of CMS' financial operations.

CMS has already implemented HIGLAS in six of our Medicare contractors, with positive results. CMS is currently transitioning from the legacy claims processors (FIs and carriers) to the new Medicare Administrative Contractors (MACs), who will use HIGLAS as they take over the claims processing responsibilities from the FIs and carriers. The immediate results are that claims have been processed more accurately and improper payments have been reduced. HIGLAS processes have resulted in an additional $9 million of interest earned in the Medicare trust funds.

HIGLAS is also a component of the Department-wide Unified Financial Management System (UFMS) initiative. HIGLAS continues its coordination efforts with HHS to ensure that internal CMS administrative accounting/financial data can be interfaced with UFMS. Unifying the systems improves the Department's data consolidation and financial reporting capabilities.

When fully implemented by 2011, HIGLAS will:

- Strengthen how we manage our accounts receivable and allow us to collect outstanding debts faster and more effectively;
- Enhance CMS' oversight of contractor financial operations, including data entry, transaction processing, and reporting;
- Produce automated financial statements and other required reports quickly, leading to fewer errors in financial reporting and a reduction in manual labor;
- Eliminate redundant accounting processes;
- Interface with the Recovery Management and Accounting System (ReMAS), which reconciles claims and payments to providers and beneficiaries when Medicare is the secondary payer, further ensuring that claims are paid appropriately;
- Be used by all Medicare Administrative Contractors;
- Assess Part C (managed care) and Part D (prescription drug) system requirements; and
- Save millions of benefit dollars each year for the Medicare program.

### Updating Outmoded Coding Systems—ICD-10

ICD-10 is the modernized update to ICD-9, the current code set for recording diagnoses and inpatient hospital procedures. ICD-10 provides a more robust, more granular, more modern and more accurate code set. ICD-10 will improve the quality of information reported on claims. This information will provide for more accurate payments and will improve quality monitoring, payment, coverage, risk adjustment, research, and statistical reporting.

Requiring the industry to move from ICD-9 to ICD-10 needs input from both Congress and the Department. Because the codes impact so many parts of CMS, the implementation process is expected to be a 4-5 year effort, starting well before the implementation date and lasting several years after. This will be a significant, agency-wide effort, impacting virtually every part of CMS and all of our partners.

### Implementing Private Sector Recovery Techniques

As part of the effort to strengthen and improve our financial management performance, and protect the Medicare Trust Funds, we considered and adopted proven private sector approaches in our program operations. For example, using innovative financial management strategies allows CMS the opportunity to integrate more efficient and effective processes into our operations and demonstrate the potential value of these approaches to other programs within HHS. Our current Medicare recovery initiatives include the use of new contracting authority provided by the Medicare Modernization Act and the consolidation of functions and workloads to maximize financial performance and ensure accurate payments.

The Medicare Modernization Act provided for a three-year demonstration project to allow CMS the ability to use recovery audit contractors (RACs) to identify underpayments and overpayments in Medicare claims, and to reimburse the contractor a percentage of the recoveries. The law also requires CMS to evaluate this project and report on savings to the Medicare program and recommendations for extending or expanding the project. Our current experience under the demonstration has resulted in a significant increase in Medicare overpayments collected without using increasing current program funding.

CMS is actively pursuing improvements in Medicare Secondary Payer (MSP) operations. To do this, CMS now has one MSP recovery contract that consists of MSP post-payment recovery work and Group Health Plan (GHP) MSP debts. Consolidating this work will improve our administration and operations, improve consistency of processes, and enhance customer service. Over the next few years, CMS will:

- Complete the three-year Recovery Audit Contractor (RAC) demonstration, in three states (CA, NY, FL), to identify and recover Medicare overpayments, use the findings to further reduce improper payments and pay the RACs on a contingency basis;
- Submit the report to Congress on the impact of the RAC demonstration and recommendations for extending or expanding the approach;
- Award the Medicare Secondary Payer Recovery Contract (MSPRC) and begin implementation of the consolidation by October 2006; and
- Oversee the MSPRC operations to ensure efficiencies in the post-payment aspects of the MSP program improve recoveries and enhance customer service.

### Implementing the National Provider Identifier (NPI)

As we continue to upgrade our systems to ensure accurate payments, high quality health care, and to reduce improper payments, CMS is implementing the HIPAA requirement for health care providers to adopt a standard unique health identifier. The NPI was adopted in 2004 as the standard unique health identifier for all health care providers. In May 2005, CMS announced the availability of the new identifier for use in the standard electronic health care transactions. One year later, CMS announced the availability of electronic file interchange (EFI), also referred to as "bulk enumeration," functionally. The EFI enumeration process allows organizations to apply for NPIs for a large number of individuals or organizations by submitting an electronic file rather than submitting a paper application or web-based application for each individual or organization. Because a file can contain thousands, even tens of thousands, of providers' applications, the administrative burden on both the provider community and CMS is greatly reduced when this process is used.

By implementing the NPI requirements as noted below, we can facilitate more accurate payments, strengthen quality assurance, and reduce improper payments.

- **May 23, 2007:** All HIPAA-covered entities such as providers completing electronic transactions, health care clearinghouses, and large health plans, must implement NPI.
- **May 23, 2008:** All small health plans must implement NPI.

### Ensuring Effective Grants Management

We use the Grants Administration, Tracking and Evaluation System (GATES) to efficiently manage administrative grants. The system streamlines the work processes within the agency. It also gives the grantee community improved services, full disclosure of all grant opportunities within the Federal government, and streamlines the application process.

We are currently transitioning the processing, paying, and accounting of the Medicaid grants into the Healthcare Intergraded General Ledger Accounting System (HIGLAS). Once completed, the HIGLAS system will enhance CMS' capability to oversee and monitor Medicaid grants by providing timelier and more comprehensive data.

### Transitioning to Medicare Administrative Contracting

In Section 911 of the MMA, the Congress mandates that the Secretary of Health and Human Services replace the current Fee-for-Service (FFS) contracting authority under Title XVIII of the Social Security Act (the Act) with the new Medicare Administrative Contractor (MAC) authority.

Referred to as Medicare contracting reform, it will improve Medicare's administrative services to beneficiaries and health care providers and will bring standard contracting principles, such as competition and performance incentives, to Medicare. Using competitive procedures, Medicare has begun to replace its current claims payment contractors, fiscal intermediaries (FIs) and carriers with new contract entities called MACs. The MMA requires that CMS compete and transition all work to MACs by October 2011. CMS expects to complete the transition by 2009, thereby realizing additional Trust Fund savings sooner.

CMS is meeting the needs of its growing beneficiary population through this initiative by:

- Improving customer service by establishing a single point-of-contact so Medicare beneficiaries and providers can get information. The MACs will serve as the point of contact for all Medicare providers and physicians in their respective jurisdictions, while beneficiary claims questions go to a Beneficiary Contact Center;
- Continuing operation of efficient provider call centers that respond to over 55M calls annually;
- Competing and awarding 23 MACs during the initial implementation phase (2005-2011);
- Making advances toward the delivery of comprehensive, patient-centered care; and
- Emphasizing the MAC role in provider education and outreach.

Although Medicare contracting reform requires a significant up-front investment, this initiative will also generate significant Trust Fund and administrative savings over time. Assuming that our proposed transition schedule is maintained, the Office of the Actuary estimates that the savings resulting from Medicare contracting reform will start in FY 2008 and will accumulate rapidly to nearly $1.5 billion through FY 2011. Beyond FY 2011, CMS projects that administrative savings, in the form of contractor cost reductions from the competitive contracting environment, could exceed $180 million annually.

The transition to the MACs will occur in three cycles as follows:

- <u>The Start-Up Cycle</u>: Will transition a small discrete workload (approximately 8.8 percent of the national workload). This cycle will allow CMS to analyze lessons learned from the

acquisition and transition process prior to implementing the bulk of the transfer. This cycle is already under way.

- Cycle One: Will complete and transition half of the balance of the workload. Lasts one year. Will subject more than 40 percent of the national workload to competition and transition at a single time.
- Cycle Two: Will complete and transition the balance of the workload. Lasts one year. Will subject more than 40 percent of the national workload to competition and transition at a single time.

### Improving Electronic Claims Processing

This initiative supports the Secretary's priority of increased use of Health Information Technology. CMS is initiating a number of projects to support more accurate and efficient electronic claims processing. It has three major parts as described below:

Electronic Data Interchange (EDI) is the automated transfer of data in a specific format following specific data content rules between a health care provider and CMS or between CMS and another health care plan. The EDI transactions allow a provider to submit transactions faster and be paid for claims faster. Doing this generally costs less than paper or manual transactions. This option has already been implemented for Medicare FFS providers and contractors. By the end of 2007, CMS expects the following results from these efforts:

- Electronic Media Claim rates will increase to 98% for intermediaries and 90% for carriers.
- Electronic Remittance Advice rates will increase to 55% for intermediaries and 35% for carriers.
- Electronic claims status volume will increase by 5% from FY 2006 level.
- Standard Paper Remittance Advice volume will be reduced by 30% as compared to FY 2005 baseline volume for both intermediaries and carriers.

CMS will develop the initial goal for eligibility query based on data collected in FY 2006 by the end of 2007.

Electronic Claims Filing (ECF) is required to be used for all Medicare claims except those from small providers and several other rare instances. Medicare provides free software to providers to enable them to use ECF. Claims may be submitted electronically to a Medicare carrier, durable medical equipment regional carrier (DMERC), or a fiscal intermediary (FI) from a provider's office using a computer with software that meets electronic filing requirements as established by the HIPAA claim standard and by meeting CMS requirements.

The Standard Front End (SFE) Project is a critical component of the modernization initiative to increase electronic claims processing. This system will be fully implemented by 2009, and it will support Medicare Administrative Contractors (MACs) operations. Establishing a SFE can reduce the problems associated with the current Medicare claim submission process by implementing common specifications for the front-end claim editing and by standardizing and simplifying the process.

### Reforming Payment Systems—Inpatient Prospective Payment System (IPPS), Ambulatory Surgical Centers (ASC), and Outpatient Prospective Payment System (OPPS)

The Medicare Payment Advisory Commission (MedPAC) and further agency analysis resulted in recommendations to change the Inpatient Prospective Payment System (IPPS). CMS' analysis suggests that the current, charge-based weights and the current diagnosis related groups (DRG) classifications result in notable distortions between payments and the relative costs of care. The revisions will improve the accuracy of payments, leading to better incentives for hospital quality

and efficiency and ensuring that payment rates relate more closely to patient resource needs. More specifically, these changes are expected to reduce incentives for hospitals to "cherry pick" or treat only the most profitable patients.

To improve the accuracy of payments to Ambulatory Surgical Centers (ASCs) and in accordance with section 626 of the MMA, CMS proposed and will finalize a new payment system for ASCs, effective January 1, 2008. The proposal expands the list of covered surgical procedures, while increasing the number of payment groups for ASC procedures in order to improve accuracy. The proposed system is based on the relative weights used in the outpatient hospital prospective payment system. The system will also contain safeguards to prevent overpayment for procedures currently provided predominantly in physician offices.

To improve the accuracy of the hospital outpatient prospective payment system (OPPS) and to create better incentives for hospitals to improve quality and efficiency, CMS proposed to base the 2007 OPPS payment rates on 2005 claims data and the most current available cost report data. CMS continues to explore means of addressing hospital and other stakeholder concerns about payment for clinic and emergency department visits, procedures that require expensive devices, and use of multiple procedure claims to set payment weights.

CMS will take action to address these concerns by:

- Publishing the proposed rule with comment explaining the changes we will make for CY 2007 payment under OPPS;
- Conducting biannual meetings of the Ambulatory Payment Classification (APC) Panel. APC is a Federal advisory committee chartered by the Secretary of HHS, composed of hospital industry representatives who advise CMS on many aspects of the OPPS from the hospital perspective; and
- Enhancing OPPS claims to ensure that the charges for all items and services are included in the claims so that the payment rates will fully reflect the total cost of the services and the claims data can be used to efficiently monitor quality of care.

### Improving the Accuracy of Payment and Quality Measurement

To improve the accuracy of quality measurements and the comparability of results across Post Acute Care (PAC) facility types and to improve the accuracy of payment for post acute care, CMS is developing a Post Acute Care Payment Reform Demonstration based on a Congressional mandate (Deficit Reduction Act Section 5008). CMS' analysis suggests that the separate payment systems, patient assessment forms, and requirements lead to problems with care continuity, the inability to compare quality results across settings and inappropriate incentives for transfer and care provision. CMS will take action to address these concerns by:

- Developing a patient assessment tool to be used in acute care hospitals and in PAC settings including Long-Term Care Hospitals (LTCHs), Independent Rehabilitation Facilities (IRFs), Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs);
- Developing a cost collection tool to access resource use in the four PAC settings; and,
- Designing a large-scale implementation of the new patient assessment tool and cost collection tool with the intent to reform payment across the four sites based on the information collected.

### Part C and Part D Payment Validation

CMS has implemented a new beneficiary level monthly payment validation process prior to payment authorization in order to confirm that the MARx calculated payments for the Medicare Advantage (MA), Part D and demonstration plans are accurate. This validation process is used to

identify any potential payment issues and to track their resolution. Generally, the types of payment issues identified will originate as systems processing issues. The focus of the beneficiary payment validation is on independently replicating the monthly payment calculations to check the validity of the MARx payment calculations starting with beneficiary level payments and then rolling these payments up to the plan and national levels. In addition, the input data sources for these payment calculations are also analyzed to validate the accurate transfer of data across different CMS data systems to the MARx system.

By the end of 2008, CMS will refine the process of validating payments made to Medicare Advantage organizations, Prescriptions Drug Plans and other organizations paid through the Medicare Advantage Prescription Drug System (MARx). We will continue to confirm that MARx calculated payments are accurate using the new beneficiary level monthly payment validation process, and will add a routine validation analysis to evaluate retrospective monthly payment adjustments. In addition, we will further automate procedures to more rapidly generate validation reports for the monthly payment decisions.

As part of this payment validation initiative, CMS will continue to document in detail the complete payment transaction process and identify existing and needed controls. Documentation will include cycle memos and standard operating procedures. New controls will be defined in detail and initiated as part of the routine payment validation process.

### Ensuring Provision of Services During Emergencies and Disasters

CMS must assure that Medicare and Medicaid providers and CMS employees are paid, even in the event of an emergency or disaster. The CMS Continuity of Operations Plan (COOP) addresses policies and procedures that enable CMS and its contractors to continue these services.

The COOP, which is updated annually, encompasses evacuation, assessment, decision-making, and relocation of designated personnel to conduct the following essential functions at an alternate site:

- Managed care organizations payments;
- Medicare Fee-for-Service special payments by fiscal intermediaries, carriers, and/or MACs;
- Medicaid/State Children's Insurance Plan budget and expenditure reporting;
- Critical payments and authorizations;
- Payroll; and
- Travel authorization.

All essential functions except travel authorization are fiscal in nature and can be delayed for at least 48 hours. The actual priority of one essential function over another depends upon when a disruptive event occurs in the CMS payment schedule. CMS staff has been designated to assist in determining which essential functions have priority during a disruptive event, and all the plans have failsafe backups.

## *3: HIGH-VALUE HEALTH CARE*

CMS supports the transformation of the nation's current health care system to one in which patients and doctors can make informed decisions about the most effective medical care, based on timely access to the latest evidence, in a way that delivers the highest value care.

This transformed system includes SMART health care, secure electronic records, electronic prescribing, health transparency based on immediate, accurate, and comparative quality and cost information, new Medicare Advantage plan designs and innovative prescription plan approaches, disease management programs, disease prevention, and value-based payment.

CMS processes an estimated 1.2 billion Medicare fee-for-service claims, handles millions of inquiries and appeals, and conducts thousands of health care facility inspections and complaint investigations. To support high-value health care, we plan to inform and support Medicare Prescription Drug plans, Medicare Advantage plans, and employer-sponsored retiree health care coverage so that beneficiaries have maximum choice of benefit options at affordable prices. We work closely with industry groups and providers, facilitate enrollment of millions of dual-and low-income subsidy eligibles, and develop policies that facilitate health plans meeting beneficiary needs while controlling costs. We collaborate with states, regions, and providers, including projects to implement survey procedures and interpretive guidelines related to organ transplants and restraint use. We also continue to work with states and provide support on 1115 demonstrations, 1915(b) waivers, train survey and certification surveyors, implement Medicaid quality initiatives, and develop and implement policies to better integrate Medicare and Medicaid.

CMS' High-value Health Care initiatives through 2009 include:

### Information Technology Modernization

The current IT modernization initiatives will have a major impact on both infrastructure and applications and will result in systems that are scalable, flexible, and responsive to policy changes, supportive of queries, and maintained on platforms that facilitate easy system-to-system communication. Modernized systems will produce consistency in the use of Medicare data and predictability in systems changes, and will increase the reliability of information used by the program's stakeholders. This will lead to improved quality of care and a better level of service for beneficiaries and providers. We are evaluating a number of options and have already undertaken several modernization initiatives.

CMS' information technology modernization efforts include:

- Consolidating the number of data centers to increase our control of data center operations and better secure protected health information;
- Integrating functions, processes and data to improve service to beneficiaries and providers;
- Implementing improvements in service levels to beneficiaries and providers through the creation of web-based services and increased access to quality data;
- Integrating help desks and call centers to enable greater control over data security and privacy, sharing of information, and service continuity across data centers;
- Enhancing the data that CMS uses to administer its programs;
- Optimizing the use of the Internet while protecting the privacy of beneficiary information, which will reduce the administrative burden on providers, help to ensure more accurate payments, and improve agency-to-provider communication;
- Implementing industry and Consolidated Health Informatics (CHI) standards in CMS systems;
- Encouraging adoption of health IT to enhance safety and reduce the burden of reporting quality measures; and
- Implementing the Clinger-Cohen Act which requires that every Federal agency develop an Enterprise Architecture (EA), a representation of the business and technical processes used by the agency to accomplish its mission. EA provides a clear and comprehensive picture of what the current business and technology environment looks like today, the

desired capability and structure of the enterprise for the future, and a transition plan to act as a roadmap from its current to its target environment. EA is a critical element in ensuring that the current and future business and technical architectures for the Agency support the HHS mission, Strategic Action Plans, and performance and outcome objectives. CMS will continue to optimize the interdependencies and interrelationships among its internal business operations and the underlying IT infrastructure and applications that support these operations.

### Medicare Prescription Drug Program

CMS' new prescription drug benefit provides seniors and people with disabilities comprehensive prescription drug coverage, the most significant improvement to senior health care in 40 years. Millions of seniors and people with disabilities are already using this benefit to save money, stay healthy, and gain peace of mind. Over 38 million Medicare beneficiaries have some type of prescription drug coverage. Since launching this benefit, we have improved our data system (particularly helping the dual eligible population), strengthened our 1-800-MEDICARE call centers, instructed plans on ways to better serve both beneficiaries and work with pharmacists, and dedicated greater CMS resources to addressing enrollee concerns. CMS' plans for the Medicare Prescription Drug Program include:

- Making sure beneficiaries can get prescriptions at a reduced cost, by building on the foundation for a strong program management structure and competitive environment;
- Providing Medicare beneficiaries with good prescription drug plan choices that provide quality services that contribute to beneficiaries' overall health and quality of life; and
- Continuing to work with partners, including states, plans, pharmacists, and advocates to ensure the continued success of the program.

### Long-Term Solvency

To potentially improve long-term solvency for CMS' programs, and to improve their sustainability over time, we have developed strategies for price and quality transparency and "value incentives" for consumers and providers. To continue our progress toward addressing long-term Medicare solvency while providing better care and sustainable coverage, we need to accelerate adopting Health Information Technology, focus more on prevention, and create more transparency. These steps will improve Medicare for current and future generations.

When we launched the prescription drug benefit earlier this year, CMS found that competition provides greater value with lower cost. In this competitive approach, private drug insurance companies are very actively competing with each other to provide the lowest premiums, best coverage, and best services on behalf of Medicare beneficiaries. Their efforts have helped hold program costs and beneficiary premiums below expectations. Moreover, beneficiaries and their caregivers, with support from Medicare and many local partners around the country, are using information on prices and coverage to choose the most appropriate benefit coverage and at the lowest annual cost. Competition with good information on quality and price has the potential to lead to cost savings in many other aspects of Medicare. CMS is beginning to implement competitive reforms in durable medical equipment, Part B drug pricing, and other areas.

The President has proposed budget reforms that will reduce Medicare spending growth and save more than $36 billion over the next 5 years (FY 2007 – FY 2011), improving Trust Fund solvency and reducing the general revenue needs of Medicare. The President's FY 2007 budget also proposes additional reforms and initiatives to improve Medicare's financial condition by preventing costly complications and getting the right care to each patient, instead of paying for more medical services. These proposals include:

- Pilot-testing quality and efficiency measures to pay more for better results rather than for more services;
- Implementing competitive bidding approaches to the delivery of care;
- Continuing to expand access to Medicare Advantage plans, which save beneficiaries around $80 a month and can help reduce overall health care costs by coordinating care and prevention;
- Promoting the adoption of interoperable Health Information Technology;
- Making Health Savings Accounts available in Medicare in 2007
- Implementing modest reductions in market basket rates of growth, including a proposed 0.4 percent reduction in the growth rate of Medicare payments (if Congress doesn't pass a specific alternative proposal to achieve needed improvements in sustainability); and
- Gradually increasing the share of program costs paid by the highest-income beneficiaries.

**Medicaid Reform Roadmap**

The Medicaid Modernization initiative is to develop and implement sustainable Medicaid programs that provide coverage for millions of people who are not covered now. People in differing economic situations will be helped through flexible benefits and incentives tailored to meet their needs. The Deficit Reduction Act of 2005 moves the program in this direction by mandating reform and giving CMS the flexibilities needed to accomplish the goals. CMS will help all states use the new benefit flexibility options to realize Medicaid innovation and efficiencies. As we do this, we will also create programs tailored to meet the needs of diverse populations through Medicaid State Plan Amendments. CMS will increase flexibility options to states by identifying a means by which States may begin the process of incorporating Health Opportunity Accounts into the Medicaid programs. People with disabilities will have access to care in their homes and communities. With Long-Term Care Reform, states will have the flexibility to give people access to health care without waivers. Self-direction will be available in long-term and acute care settings. We will increase access to community-based long-term care. The integrity of Medicaid will be assured, while also guarding against financial abuse. The Deficit Reduction Act of 2005 affords States the voluntary opportunity to reform their long-term care delivery system in a variety of ways through grant programs and multiple state plan options. CMS efforts to reform Medicaid include:

- Providing clear policy direction and encouraging all states to use new benefit flexibility options (including Health Opportunity Accounts) to realize Medicaid innovation and efficiencies while creating programs tailored to meet the needs of diverse populations through Medicaid State Plan Amendments;
- Administering grant programs included in the Deficit Reduction Act of 2005 which were designed to promote innovation and expand benefits and coverage. Grants include the Transformation Grants, High Risk Pool Grants, and grants for the establishment of alternate non-emergency services providers;
- Providing states with flexibility through the approval of their application for 1115 Demonstrations and 1915(b) Waivers with parameters that could include reducing uninsured, promotion of personal responsibility, budget neutrality and program outcomes evaluation;
- Developing mechanisms to provide support to states in rebalancing long-term care systems and increasing the number of individuals transitioned from institutions to communities;
- Developing measures to determine the effectiveness of rebalancing efforts;
- Implementing the Medicaid Quality Improvement Strategy to support states in their efforts to promote safe, effective, efficient, timely, equitable and patient-centered care;
- Providing guidance to State Medicaid Agencies on how to become a long-term "Partnership State;"

- Increasing the number of people who have the option to self-directed services through the new self-directed personal care state plan option, the new Home and Community Based Services (HCBS) State plan option, and HCBS waivers; and
- Creating a person-centered vision for the future of the LTC, to serve as a blueprint for the long-range effort to reform the system over the next decade.

### State Child Health Insurance Program (SCHIP) Reauthorization

The State Child Health Insurance Program was authorized through Title XXI of the Social Security Act and is jointly financed by the Federal and State governments and administered by the states. Within broad Federal guidelines, each state designs its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. This important program has expanded health care coverage to millions of children; however, the program is currently only authorized through fiscal year 2007. To ensure continued coverage of eligible children through the SCHIP program CMS will:

- Work with Congress to provide information necessary for reauthorization of the program.
- Maintain program operations and implement any new provisions of the program when reauthorization is obtained.

### The New Orleans Health System

CMS is developing a redesign project with the goal of producing an appropriate, comprehensive, system-wide Medicaid waiver and Medicare demonstration proposal to accomplish the Secretary's vision for the Greater New Orleans area. We are actively developing direct relationships with beneficiaries through personalized tools and with the cooperation of a well-developed grassroots network of partners. Specifically, CMS activities related to this initiative include:

- Supporting and helping the Louisiana Health Care Redesign Collaborative as it develops a practical blueprint for an evidence-based, quality-driven health care system for Greater New Orleans;
- Encouraging the Collaborative to expeditiously prepare an appropriate, comprehensive, system-wide Medicaid Waiver and Medicare Demonstration proposal for the Greater New Orleans area that will guide the rebuilding of its health care system;
- Leveraging the power, resources and authority of other HHS operating divisions and other Federal agencies to redesign the health system as efficiently and effectively as possible; and
- Monitoring expenditure of funds allocated through the DRA for the rebuilding process.

### Prevention and Quality Care

We are at a turning point. Medicare is providing new up-to-date preventive benefits and prescription drug coverage to prevent disease complications for beneficiaries with chronic illness. To take full advantage of this support and the improved benefits, we need to take steps to encourage, support, and reward the effective use of these benefits to provide high-quality care. CMS efforts to increase prevention services and quality of care include:

- Increasing the use of Medicare preventive screenings such as the "Welcome to Medicare Physical," diabetes screenings and counseling;
- Reducing disparities in effective preventive services by measuring current national trends and statistics;
- Producing annual Quality and Disparities reports to increase the use of preventive services by racial and ethnic minorities;
- Evaluating future needs of the population and the levels of evidence required to incorporate personalized health risk assessment, screening, and disease prevention intervention;

- Examining new economic models for the diagnostics industry that stimulate commercial development of cost-effective health screening and monitoring approaches;
- Evaluating evidence-based protocol management of health systems, ensuring that they include standardized safety and disease response and outcome measures;
- Supporting innovative knowledge engineering and developing new clinical decision support and service delivery models for personalized health choices to prepare for the adoption of advanced technologies in the marketplace based on consumer-family history and genetic-based risk assessment;
- Continuing support for the value-based purchasing system for hospital pay-for-reporting and the physician voluntary reporting program, which will include preventive services measures;
- Continuing to offer and promote a broad array of free provider educational products geared to enhance the providers understanding of preventive benefits;
- Developing new Medicare Advantage plan types, such as dual eligible and chronic care special needs plans, to improve overall cost and quality outcomes for high risk populations and increase integration and coordination with state Medicaid Programs for dually eligible Medicare beneficiaries; and
- Supporting drug plan sponsors in their efforts to improve care coordination and to develop innovative approaches to improving the quality of care for our beneficiaries.

### Pay-for-Performance

CMS' strategic objective is to shift to a quality-oriented, patient-centered payment system. Because payment for care should be based on a patient's needs rather than on the type of facility that provides the care, we are developing a single assessment instrument for hospitals, nursing homes and home health agencies. CMS is also working to implement a pay-for-performance system (P4P), which rewards providers on the basis of quality (patient outcomes) and efficiency (less waste). Rewarding higher quality and better efficiency benefits both Medicare beneficiaries and the Medicare program.

We have joined the growing consensus that the best way to help health care providers deliver high-quality, efficient care is to provide positive financial incentives. MedPAC and bipartisan members of Congress have urged Medicare to provide financial incentives for both higher-quality and efficient care. And leading provider groups representing physicians, hospitals, nursing homes, dialysis centers, and others have also endorsed the movement toward quality-based payments that improve patient care. As in our other initiatives, we'll be looking to health care providers to help lead this effort. We are implementing and evaluating these payment reforms now. Efforts related to Pay-for-Performance include:

- Collaborating with Premier, Inc., a group of non-profit hospitals, to operate a demonstration to improve their quality of care by tracking and reporting quality data for 34 measures at each of about 270 participating hospitals;
- Using the lessons learned from the Premier demonstration to shape our future hospital pay-for-performance initiatives and help us develop a hospital pay-for-performance plan as mandated by the Deficit Reduction Act section 5001 (b);
- Operating the Physician Group Practice demonstration, implemented in April 2005, to provide rewards to large, multi-specialty group practices for improving the quality of care and reducing the cost increases for their patients;
- Working to bring better continuity of care and support for chronically ill beneficiaries in our traditional Medicare plan, by creating financial incentives for care coordination through our Medicare Health Support (MHS) initiative and other disease management initiatives;

- Paying organizations to help chronically ill Medicare beneficiaries get better support, treatment and continuity of care within Medicare Advantage health plans, including HMOs, PPOs, and fee-for-service plans that offer additional benefits;
- Working with states on Medicaid waiver and demonstration programs that provide financial support for improvements in quality, beneficiary outcomes, and costs;
- Conducting the Medicare Demonstration Project to Permit Gainsharing Arrangements (DRA Section 5007) and other demonstrations under our authority to promote collaboration between hospitals and physicians to improve care. The hospital provides for gainsharing payments to the physicians that are based on the savings incurred directly as a result of collaborative efforts between the hospital and the physician.
- As part of the development of the Medicare Hospital Pay-for-Performance Plan, CMS is evaluating innovative uses to expand competitive bidding for episodes of care and exploring ways Medicare could incorporate this approach in the hospital value-based purchasing program. Competitive bidding programs would provide positive financial quality incentives to winning providers and suppliers based on a combination of quality and efficiency measures.
- Advancing the progress that has been made in the early stages of implementing pay-for-performance in the following settings: hospital, physician, home health, skilled nursing and renal dialysis facilities. Early initiatives include the hospital pay-for-reporting program and physician voluntary reporting program.

### Quality and Cost Measurement in Medicare Fee-for-Service Systems

CMS has many important opportunities to help health professionals, patients, and all of the stakeholders in our health care systems turn promising new ideas into action. What our agency does about quality in Medicare and Medicaid has great impact on the future of health care. By supporting the transformation of our health care system to prevention-oriented coverage, Medicare has tremendous opportunities to help our health care system deliver higher-quality care in both the acute and post-acute care settings.

We want our health care system to deliver:

- The right care, for the right patient, at the right time;
- High-quality care that is safe, effective, efficient, patient-centered, timely, and equitable;
- Care that is personalized, prevention-oriented, and patient-centered, based on evidence about the benefits and costs for each particular patient; and
- Care that is based on 21st Century biomedical science, science that is marked by new approaches in the lab such as genomics, nanotechnology, and next-generation information technology. These new sciences are only just beginning to have an impact on patient care, but they hold tremendous potential. CMS will encourage cross-licensing agreements among inventors of fundamental technologies such as genomic and proteomics patents as well as research tools to streamline integration of components into health care deliverables.

### Our Integrated Data Strategy

Our Integrated Data Strategy (IDS) is the centerpiece of the new CMS data environment. It is the foundation for sharing data at all levels within CMS, HHS, other Government entities, and external business partners. CMS has established a series of goals that are fundamental to achieving its vision of providing a centralized, scalable, enterprise-wide repository for the Agency's health care data. The high-level goals for the IDS are to:

- Transition from a claims-centric orientation to a multi-view orientation that includes Beneficiaries, Providers, Health Plans, Claims, Drugs, and other views as needed;
- Provide uniform privacy and security controls;

- Provide database scalability to meet current and expanding volumes of CMS data;
- Transition from a stove-piped approach to a highly integrated data environment for the enterprise;
- Integrate data from such other sources as the Food & Drug Administration (FDA), Department of Veterans Affairs (VA), and Department of Defense; and
- Let users analyze the data in place rather than rely on data extracts.

The IDS implementation will incrementally incorporate new datasets within four phases: Phase 1 - Medicare Drug and Beneficiary Data; Phase II - Medicare Part A & B Claims Data; Phase III - State Medicaid Data; Phase IV - Historical Data.

**Informed Provider Community**

CMS must work closely with the provider community to make sure that they support high quality services to beneficiaries. This relationship requires that CMS fulfill its responsibility to offer the provider community timely and accurate information, prompt response to inquiries and comprehensive education outreach about CMS programmatic initiatives such as new payment systems, NPI, prevention, and reducing overpayments. To continuously enhance the ability to keep providers informed, we will:

- Expand and improve the technology that supports communication to providers and increases the availability of electronic and web based transactions.
- Continue to pursue all opportunities to engage in a two-way dialogue with providers. By listening, CMS programs are improved and operational burden minimized.
- Continue a comprehensive provider education program using the CMS.gov Provider Center, Medicare Learning Network educational products including "MLN Matters," expanded provider listservs, FI/carrier/MAC outreach, and Regional Office outreach activities.

This level of service to the provider community encourages providers to partner with CMS and help reach the beneficiary whenever there is important information that individual beneficiaries need to know.

## *4: CONFIDENT, INFORMED CONSUMERS*

CMS will develop personal relationships with beneficiaries through the use of increasingly personalized tools and with the cooperation of a well-developed grassroots network of partners. The goal is to ensure that our beneficiaries become confident, well-informed consumers that make maximum use of the program. Doing this will result in a successful system of personalized health care – the right care at the right time. Consumers will participate in SMART health care and have immediate access to affordable Medicare prescription drugs, comparative information on quality and cost, flexible Medicaid benefits and incentives, and access to care in homes and communities for the disabled population. The New Orleans Health System will become prevention-centered, neighborhood-located and electronically-connected.

CMS' ongoing projects include efforts to maintain and expand our use of technology, including beneficiary e-Services via medicare.gov and upgraded call centers. Our efforts also include maintaining a multi-pronged approach for various outreach and awareness campaigns at the national, regional, and local levels regarding beneficiary rights, benefits, and health care options. We support the activities of the Ombudsman in helping beneficiaries make better health care choices in addition to providing technical assistance and training to stakeholders involved in educating beneficiaries about Medicare. Through expanded use of the self-directed personal care

state plan option, the new Home and Community Based Services (HCBS) State plan option, and HCBS waivers, we are increasing the number of people who have the option to self-directed Medicaid services. We are also developing and disseminating patient-focused promotional materials designed to communicate the Agency's various health care initiatives to promote good health and disease prevention.

CMS' initiatives through 2009 include:

### Personal Health Records (PHR)

CMS continues to work to give our beneficiaries more control and use of their own electronic health information, with their permission and control and with full security protections. We have launched the Medicare Beneficiary Portal at my.medicare.gov, an online tool that will enable beneficiaries to get access to all their Medicare information, such as Fee-for-Service (FFS) claims, deductibles, eligibility, enrollment and other personal data. Implementing PHRs also means enhancing our security systems. We are the largest maintainer of health-related information in the world. CMS is committed to protecting the security and privacy of our sensitive beneficiary health care data. How we protect and manage that information is not only a critical service for our customers, but it sets a standard for the larger health care system. CMS will continue promoting the use of personal health records by:

- Conducting a PHR feasibility study;
- Actively supporting the PHR activities of the Office of the National Coordinator (ONC) and the American Health Information Community (AHIC);
- Developing a process for the secure transmission of Medicare information to populate the PHRs for beneficiaries who have chosen to use them;
- Participating in Secretary's Advisory committee for EHR, AHIC; and
- Working with industry groups on developing standards for PHRs that will support the Medicare and Medicaid populations.

### Electronic Prescribing

The ability to create electronic prescriptions (e-Rx) has obvious implications for quality improvement and cost savings. Medication errors due to handwriting or similar errors caused by a paper-based process can be significantly reduced by prescribing through a computer or hand-held device and electronically transmitting that prescription to a pharmacy. The Medicare Modernization Act requires us to implement e-prescribing no later than 2009. This e-prescribing requirement is also a stepping stone in moving the Secretary's Health Information Technology initiative forward. We have already significantly accelerated the e-prescribing schedule by publishing a set of standards for communicating basic e-prescribing transactions and awarded contracts to conduct five pilot programs that will test additional standards, interoperability and workflow. We will continue in this direction by:

- Developing plans to inform and educate health professionals, and to partner with key players in the health care industry to encourage adoption of e-prescribing;
- Evaluating the pilots and report to Congress the results in 2007; and
- Promulgating final uniform standards in 2008

### Beneficiary Contact Centers

A key outcome of reforming the fee-for-service environment, responding to a projected 40 million calls a year, and improving customer service in Medicare is the implementation of the Beneficiary Contact Center. By focusing our operations on larger call center contractors we are able to improve operational efficiency, reduce operating costs and improve service to callers (more consistent and accurate). This strategy allows us to respond quickly and efficiently to general

inquiries that will be handled by the Internet, national IVR and 1-800-MEDICARE customer service representatives while routing more complex telephone inquiries to contractors providing the best value and the most qualified agents. Additionally, we are able to develop and implement centralized standards and approaches to core call center functions, i.e., quality assurance, training development, and content development, so that beneficiaries get understandable, usable, and accurate information every time. Specifically, the CMS strategy includes:

- Maintaining the network Interactive Voice Response (IVR) system that will provide beneficiaries 24X7 access to information;
- Making 1-800 MEDICARE's standard desktop, the Next Generation Desktop (NGD), the standard desktop for all call centers so that all the virtual call centers have access to all data systems necessary to answer Medicare inquiries; and
- Establishing one national information warehouse.

**Money to follow the person (MFP) in State Medicaid program**

The 2005 Deficit Reduction Act authorizes the Secretary to award grants to States to eliminate barriers or mechanisms that prevent or restrict the flexible use of Medicaid funds. The grants were created to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term care services in the setting of their choice. Specifically, CMS will be:

- Offering $1.75 billion in competitive grants to the states for a period of 5 years, starting in January 2007;
- Giving an MFP-enhanced Federal Medical Assistance Percentage rate for a period of one year for each person that the State transitions from an institution to the community; and
- Educating states about the benefits and availability of the MFP program.

**Up-to-date Medicaid benefit choices and personal consumer responsibility about health care choices**

Medicaid has tremendous potential to give beneficiaries more choice, especially with the implementation of the DRA. DRA gives states many more options of delivering benefits. CMS will encourage all states to use these new benefit flexibility options to realize Medicaid innovation and efficiencies. To this end, we will be:

- Providing clear policy direction to help all states to use new benefit flexibility options;
- Reviewing and approving benefit flexibility State Plan Amendments expeditiously; and
- Increasing flexibility options to States by identifying ways states may begin the process of incorporating Health Opportunity Accounts into the Medicaid programs.

**Medicare Health Support Pilot Program**

Section 721 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 authorized the development and testing of voluntary chronic care improvement programs, called Medicare Health Support programs, to improve the quality of care and life for people living with multiple chronic illnesses. Implementation of the Medicare Health Support program is the first large-scale initiative of this type for selected chronically ill populations in traditional fee-for-service Medicare. This new Medicare initiative is designed to help reduce health risks, improve quality of life, and provide savings to the beneficiaries and to Medicare. As of Spring 2006, more than 120,000 Medicare beneficiaries had agreed to participate in these programs. Now that these pilots are underway, we will continue to evaluate the progress of these pilots, and will be

- Submitting an interim report to Congress on progress to date in 2007; and
- Submitting a second report to Congress on pilot findings in 2009.

**Pandemic Flu**

HHS is engaged in a broad array of activities to prepare for an influenza pandemic, and CMS plays a supportive role in this effort. Building off of the successful development and implementation of our Continuity of Operations Plan, we have developed a plan in the event of an influenza pandemic that supports the HHS plan. We have established relationships with Federal, State, and local officials, and tribal partners and are able to work with them to develop surge capacity for deploying of medical resources during an outbreak. To further our preparedness, CMS efforts include:

- Developing policy-specific: (a) standards for emergency preparedness for providers and agents, (b) standards for quality and service delivery performance, and (c) policies and procedures for adjusting standards to match emergency situations (e.g., waivers or deferrals under section 1135 authority);
- Enhancing Business Continuity Plan (BCP) policies that address critical employees, time and compensation issues, continuity of business functions, work at home;
- Continue building and maintaining employee call rosters and critical employees;
- Continuing to train critical employees on duties and responsibilities and cross-train staff on essential functions;
- Strengthening shelter-in-place (SIP) plans and train critical employees on shelter-in-place/quarantine possibilities; and,
- Conducting tests and exercises to assess, validate, or identify a subsequent corrective action for specific aspects of plans, policies, procedures, systems and facilities used in response to an emergency situation.

**Transparency: Availability of accurate and comparative information for beneficiaries**

During the drug benefit implementation, we saw beneficiaries input their specific drug information to get detailed reports on which drug plan would provide the greatest value. We are well-positioned to update our award-winning comparative tools. During the next few years, we will be:

- Working to use up-to-date IT systems to help beneficiaries and the organizations that support them to get the personalized assistance they need to take advantage of Medicare's new coverage and new information on quality and costs;
- Continuing to improve and expand the content of Hospital Compare, Home Health Compare, Nursing Home Compare, and Dialysis Facility Compare;
- Developing transparency collaborations to ensure beneficiaries get the best quality care for the best price by developing ways to let a beneficiary know their medical options, the quality and expertise of doctors and hospitals in their area, and what their medical care will cost them before they need a specific type of care.
- Encouraging our beneficiaries to become more confident and informed participants in choosing their health care; and,
- Publishing reimbursements rates for common procedures and treatments.

**Transparency: Quality information on disease prevention and management**

CMS is working to support and collaborate on the development of useful quality measures in virtually all areas of care. Much of this activity is taking place through broad partnerships focused on measuring quality and then achieving measurable improvements in quality. CMS is one of many stakeholder participants in these collaborations. The measures being developed, applied, and improved through these collaborations include:

- Expanding the hospital quality measures to include outcomes such as patient satisfaction and surgical complications. These measures are developed through the joint efforts of CMS, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the

Agency for Healthcare Research & Quality (AHRQ), and members of the Hospital Quality Alliance (HQA), and endorsed by the National Quality Forum.

- Developing measures of ambulatory care quality and efficiency;
- Continue enhancing nursing home quality with the Nursing Home Quality Initiative, taking further steps to improve additional important outcomes and efficiency, such as to reduce pressure ulcers and avoid hospital admissions with preventable complications;
- Providing information on health plan performance (including prescription drug plans);
- Collaborating in other areas of quality measurement, including home health care, dialysis care, and performance measures specifically related to Medicaid and SCHIP populations;
- Improving cancer care, which involves measurement in an effort to understand what care is actually being provided and whether it is meeting our beneficiaries' needs for comfort and support; and
- Continuing to support and rely on the National Quality Forum (NQF).

**Medicare Advantage**

In 2006, all Medicare beneficiaries have access to at least one type of private Medicare Advantage plan. The increase in access (up from 77 percent in 2004) stems largely from the creation of new Medicare regional PPOs and the expansion of private Medicare fee-for-service plans. With Medicare Advantage, beneficiaries can save about $80 a month compared to the traditional plan with or without a Medigap plan they purchase on their own.

To continue to ensure Medicare Advantage is universally available, and ensuring beneficiary choices, CMS will:

- Continue to encourage new regional PPOs so that the availability of regional PPOs extends beyond the 2006 level of 70 percent;
- Continue to educate health plan organizations and encourage plans to participate;
- Continue to streamline and automate the application and bidding process to reduce the burden for plan participation; and
- Use the stabilization fund (under the authority of the Secretary), to provide incentives to Regional PPOs to remain in areas with below-national-average MA market penetration or enter MA regions with low or no participation by reducing administrative obstacles to using the fund data systems capacity for Baby Boomers.

**Data systems capacity for Baby Boomers**

The baby boomers are a different population than our current beneficiaries. They are more willing to put their health data in an electronic format; they are more Internet savvy. Baby Boomers will use our tools to assist their parents (current beneficiaries), and ultimately to address their own needs. Unless we are modernizing our systems, we won't be able to sustain our programs. Accordingly, over the next few years, we will:

- Maintain a robust, stable, and modernized enterprise-wide IT environment;
- Implement the Medicare and Medicaid IT Architecture;
- Strengthen the data infrastructure;
- Implement an Integrated Data Repository
- Continue maturation of the CMS Enterprise Architecture; and
- Continue to implement the enterprise data centers.

**Beneficiary outreach and education on coverage, services, and privacy**

CMS is committed to protecting the security and privacy of our sensitive beneficiary health care data. As we continue to implement the Health Information Technology strategy, CMS must continue to ensure the public that we are safeguarding individual privacy and ensure they

understand not only the program coverage and services, but also their privacy rights and protections. To that end, we will:

- Continue to use the media to alert beneficiaries of activities that may infringe these rights;
- Continue to use and expand our many information vehicles (medicare.gov, 1-800-MEDICARE, publications/fact sheets) and partners to educate beneficiaries on coverage, services, and the privacy and security of their personal information; and
- Integrate the CMS Office of External Affairs with supporting program goals by 2009.

## *5: COLLABORATIVE PARTNERSHIPS*

CMS recognizes that its success is dependent on collaborative relationships with a variety of organizations, individuals, and institutions, such as the U.S. Congress, states, physicians, hospitals, other provider types, professional societies, health plans, employers, State Health Insurance Assistance Programs (SHIPs), community grassroots, and other organizations, building upon our recent collaborative experiences and partnerships in successfully implementing Medicare Part D.

A partnership with CMS consists of organizations coming together around issues that affect a common population. By working together, partners extend the reach and impact of programs aimed to improve the health and wellness of seniors, children, families, and people with disabilities, and indirectly impact caregivers and employers. A partnership with CMS allows the partners to leverage their resources and expertise, and to share access to CMS' training and educational materials, research, and a connection to the Regional Offices.

The CMS definition of partnership is expanded to allow for meaningful two-way exchange and true collaboration for all CMS programs and special initiatives.

### Internal Customer Service

To ensure success with external partnerships, CMS must recognize that the practice of partnership begins internally, starting with mutually-supportive working relationships between all components. CMS employees must make a conscious effort to support one another in our work, incorporating cross-component communication and integration. To support this, CMS will:

- Integrate the CMS Office of External Affairs into a primary role with respect to the program goals, ensuring appropriate roles for partnership, media, and intergovernmental affairs;
- Develop cross-component work teams as appropriate;
- Continue Regional Offices' role as "on-the-ground" resources in planning and implementing agency outreach initiatives; and
- Continue the commitment to provide training for relationship management and work teams.

### External Partners

To achieve real improvements in quality, we need to work together in partnership with other stakeholders from throughout our health care system. We have opportunities for system-wide quality improvement today because of the broad interest, commitment, and momentum to create and sustain a better environment for high-quality, personalized care for every patient every time. This is not a CMS-led effort – it comes from all parts of our health care system. Our system has the advantages of flexibility and responsiveness to new ideas and to individual patient needs. We aren't as constrained by "one-size-fits-all" rules that are increasingly bad fits in modern health care. This is important, with all the promising new approaches for delivering health care. But the pluralism of our system also means no one entity can close the quality gap by itself. And because

CMS is such an important part of the health care system, the agency must participate actively as full partners in these collaborative efforts.

Our external partnerships include both new or enhanced collaborations with other government agencies and unprecedented collaborations with many health advocacy, research, and provider organizations. Our government partners include agencies such as the Administration on Aging (AoA), Health Resources & Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), U.S. Department of Agriculture (USDA), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), the Veterans Administration (VA), Social Security Administration (SSA), Railroad Retirement Board (RRB), Office of Personnel Management (OPM), and the Department of Defense (DoD).

To move the quality agenda forward, we are also engaging in numerous partnerships with non-governmental organizations where specific opportunities for short-term improvements in quality exist. Examples of the central role of strong partnerships in the CMS Quality Roadmap include:

- Partnering with public- and private-sector groups in the Institute for Health Care;
- Partnering with the Institute for Healthcare Improvement's (IHI) "Campaign to Save 100,000 Lives", involving dozens of partners and about 2000 enrolled hospitals focused on reducing the hospital mortality rate;
- Partnering with the Surgical Care Improvement Partnership, a public-private group led by the American College of Surgeons that is working together to reduce surgical complications;
- Partnering with the Fistula First National Renal Coalition, in which a dozen partners are promoting the best evidence-based approach to vascular access for hemodialysis patients;
- Partnering with the Alliance for Cardiac Care Excellence alongside more than 30 organizations supporting four specific, major improvements in cardiac care;
- Partnering with the quality alliances, including the Hospital Quality Alliance (HQA), Ambulatory Quality Alliance (AQA), Pharmacy Quality Alliance (PQA), and National Quality Forum (NQF) to implement performance measures;
- Partnering with medical societies, like the American Medical Association (AMA) and medical specialty societies, to support quality initiatives;
- Partnering with the National Initiative for Children's Healthcare Quality to improve the outcomes of low-birth weight infants;
- Partnering with the Centers for Health Care Strategies on Medicaid quality improvement initiatives related to the business case for quality, disparities and value based purchasing;
- Partnering with the Institute for Quality Laboratory Management (IQLM); and
- Participating in the Department's efforts for interoperability of IT systems, which include collaboration with America's Health Information Community (AHIC), the Health Information Technology Standards Panel (HITSP), the Federal Health Architecture (FHA), Consolidated Health Informatics (CHI), and others.

We are also engaging in focused "breakthrough" projects to achieve large improvements in specific areas where large quality gaps have been demonstrated and stakeholders have identified specific steps to improve performance. For example, to substantially increase influenza immunization in nursing homes requires not only participation of and coordination across CMS components and the Long-term Care Task Force (to develop policy, improve payment, track participation, provide education, share quality information, and provide technical assistance), but also coordinating with nursing homes, vaccine providers, states, and others.

In addition, we aim to establish collaborative partnerships with other insurers in the U.S. health care system. Our beneficiaries' health and health behaviors are affected by a lifetime of experience well before they enter our programs. Working with employers and other social insurance organizations to exchange and implement ideas on how to provide a sustained and coordinated focus on quality benefits the whole U.S. population – not just our individual programs.

In continuing these initiatives, and developing others, CMS will implement proven partnership techniques, such as:

- Using a collaborative approach, CMS will continue to develop health and grassroots networks for Medicare and Medicaid through an integrated cross-component effort within CMS and HHS;
- Targeting key partners and stakeholders early in the development process of new initiatives to build buy-in and support, to capture the maximum input from partners, and to use nontraditional partners to "get our message out" timely and consistently;
- Managing partner relationships on a regular, ongoing basis through visits, phone calls, and emails, employing two-way communication techniques;
- Continuing the Regional Offices' role as primary resources in planning and implementing agency outreach initiatives, and for working collaboratively with local and grassroots partners and coalitions to develop effective campaigns for informing, educating, and assisting beneficiaries with health care options;
- Maintaining and enhancing relationships with State and local professional societies and providers, as well as with the National societies and associations;
- Expanding our communication activities to allow us to have well established interactions with outside groups;
- Establishing ties with quality alliances and local communities to support getting better health care; and
- Expanding our collaborative relationships with additional organizations in health care technology, SMART health care, prevention, and health transparency to support the transformation of health care.

### Health Plans and Prescription Drug Plan Sponsors

To continuously improve beneficiary choices and awareness of Medicare managed care products and prescription drug coverage we will work with our private sector health plan and prescription drug plan partners, various industry and trade groups and beneficiary organizations. We will work in collaboration with our private sector counterparts to design, develop and deliver integrated, high quality health care and prescription drug products that meet the needs of our customers, the Medicare beneficiaries, and meet the demands of the competitive marketplace. We will work with beneficiary groups to understand their perspectives on our products. To support this CMS will:

- Encourage Medicare Advantage plans and Part D sponsors to identify approaches to achieving high quality, cost effective health care;
- Identify policy opportunities that encourage the offering of health plans and prescription drug plans that combine effective care management techniques and prescription drug coverage for the beneficiary;
- Work with plan organizations and Part D sponsors, and industry groups to identify product designs that meet the needs of the beneficiaries and the marketplace;
- Collaborate with beneficiary and consumer groups to identify product designs that tailor to the needs of Medicare beneficiaries and subgroups;
- Improve information interchange among health plans and prescription drug plans that combine coordination of benefits for our beneficiaries;

- Leverage our partnerships with Medicare Advantage plans, Part D sponsors, and industry groups to expand our opportunities for delivering innovative health care delivery products to Medicare beneficiaries; and
- In coordination with our partners, develop accurate and understandable performance metrics and quality information to assist beneficiaries in making informed decisions on their health care and prescription drug coverage needs.

**Intergovernmental Affairs**

State and local partnerships are critical to carrying out the mission of CMS. Our State and local partners communicate information to our beneficiaries about CMS' activities and programs and help us carry out agency policies. CMS is more than a liaison to the states. We will continue to garner partner participation, coordinated by the CMS partnership team. We not only want our State and local partners to receive our information, but to join us in improving health care for our beneficiaries. We will continue our partnership development with State and local governments by:

- Designing and executing the Agency's communication plan, coordinating notification of pending actions with partner groups, and serving as liaison between the states and the agency to broker relations with the states over pending changes in Medicaid, both MMA and DRA related;
- Fostering our relationships with the Governors, State legislators, and increasing our interactions with State and local elected officials, as well as the many State and local government associations such as the National Governors Associations, Council of State Governments, National Association of State Medicaid Directors, and the National Council of State Legislators; and
- Continuing to develop these partnerships at the local level and expanding the outreach to include a more comprehensive group of State and local partners by including county governments, State health insurance commissioners, State and local intergovernmental groups, and community health centers operated by local governments.

**Legislative/Congressional Affairs**

CMS works with the U.S. Congress to promote beneficiary interests by effectively presenting the Agency's position to Congress and by making the Agency aware of congressional positions on issues relevant to the Agency. In addition, we advance the Administration's policy goals and objectives by:

- Communicating CMS positions to Congress clearly and effectively;
- Communicating Congress' position to CMS;
- Providing prompt and meaningful responses to congressional inquiries;
- Providing accurate and informed technical assistance during the development of legislation; and
- Collaborating with other CMS components and administration partners to advance departmental legislative priorities.

**State Health Insurance Assistance Program (SHIPs)**

The State Health Insurance Assistance Program, or SHIP, is a state-administered CMS grant program, funded jointly with federal, state, and local community funds, that offers local, personalized counseling and assistance to people with Medicare and their families. States are allowed latitude in how their programs are structured and services provided. However, programs must offer services to all eligible persons requesting assistance, develop an intra-State agency referral system, and communicate timely and accurate health insurance information. The SHIP network is strong, established, and experienced in providing service to the Medicare beneficiaries. SHIP programs have traditionally provided outreach and training to local organizations that serve

beneficiaries; therefore, they can serve as key partners for strategic planning and implementation at national, state and local levels.

CMS will further integrate the SHIP network into collaborative activities by:

- Including representatives of the network in CMS' strategic planning processes on both a national and regional level;
- Integrating the SHIPs into CMS' national partners' strategic planning processes and the regional and local planning processes early in the process, as part of that collaborative effort;
- Setting mutual expectations of the SHIPs' and CMS' roles in state and local planning, and implementing the resulting operational plans;
- Involving SHIPs in planning and assessing the accountability measures for expected outcomes of mutually-implemented operations; and
- Expanding the open door process for the SHIPs to promote feedback to CMS and supply program improvement.

Success in engaging the SHIP Network in CMS' collaborative planning and implementation processes will result in effective outcomes for all HHS priorities.

- Health Information Technology will be understood and championed by those who provide direct beneficiary services and community training.
- The Medicare Drug Benefit will be promoted and enrollment assistance provided by SHIPs and their partners.
- Medicare Modernization will have benefited by input from a network that on a daily basis deals with the barriers and issues of the existing systems.
- The New Orleans Health System will have local support and input to issues to be tackled.
- The value of preventive benefits to the communities SHIPs serve can be communicated in a manner that will resonate both with their partners and the beneficiaries they serve.
- Rapid response planning for Pandemic Preparedness can have state and local systems input and readiness for implementation at a local level, in part, through the SHIPs and their community partners.
- Community-level buy–in and understanding of health care for the individual can be achieved by local collaborations that focus on disease prevalence in their communities.
- Effective strategies to reach and serve people with disabilities in their communities will be implemented.

# Attachment A – Secretary’s 500 Day Plan with a 5000 Day Horizon

### 500-Day Plan Information

"I enjoy solving problems and am guided by selected long-term goals. I then rely on a 500-day plan to create a timetable of short-term actions that chart a course for future progress. It's a 500-day plan with a 5,000-day horizon."

--HHS Secretary Mike Leavitt

### What It Is

Secretary Mike Leavitt uses a 500-Day Plan as a management tool to guide his energies in fulfilling the President's vision of a healthier and more hopeful America. The plan is a personal expression of many of Secretary Leavitt's priorities and provides direction to the daily leadership and management of the Department.

The strategies in the Plan focus on actions during a rolling 500-day period that will achieve significant progress for the American people over the long term. The plan is both flexible and dynamic, and it will be updated every 200 days.

### What It Is Not

It may be helpful to describe what the 500-Day Plan is not. It is not an exhaustive list of the Department’s priorities; it is a simple declaration of the Secretary's key focus areas. It does not replace the HHS strategic plan; it complements it. It does not cover all of the Secretary's priorities, but it is what he will spend at least half of his time on. It includes actions the Department can complete within 500 days that will yield results within 5,000 days.

### Principles

Secretary Mike Leavitt subscribes to a core set of public policy principles. These principles of governance form the philosophical backbone for how he approaches and solves problems. The ten principles, listed below, are not all inclusive, but do provide the philosophical underpinnings for his 500-Day Plan.

1. Care for the truly needy, foster self-reliance.
2. National standards, neighborhood solutions.
3. Collaboration, not polarization.
4. Solutions transcend political boundaries.
5. Markets before mandates.
6. Protect privacy.
7. Science for facts, process for priorities.
8. Reward results, not programs.

9. Change a heart, change a nation.
10. Value life.

### Transform the Healthcare System

In 5,000 days, the Secretary sees a nation in which...

- Nearly all health records can be linked through an interoperable system that protects privacy as it connects patients, providers and payers – resulting in fewer medical mistakes, less hassle, lower costs and better health.
- Consumers are better informed and have more choices.
- Wellness and prevention are sought as rigorously as treatment.
- New drugs and innovation are rapidly approved and continually monitored afterwards, and new information is proactively communicated to providers and patients.
- Payers reward providers for healthy outcomes as well as quantity of care and services.
- 12-14 million more Americans have health insurance.
- Inequalities in health care are eliminated.
- Common sense medical liability reform makes health care more affordable and accessible for all Americans.

In the next 500 days the Secretary will concentrate on...

- Expressing a clear vision of health information technology that conveys the benefits to patients, providers and payers.
- Convening a national collaboration to further develop, set and certify health information technology standards and outcomes for interoperability, privacy and data exchange.
- Realizing the near-term benefits of health information technology in the focused areas of adverse drug-incident reporting, e-prescribing, lab and claims-sharing data, clinic registrations and insurance forms.
- Creating a drug safety board to monitor and respond to post-market adverse drug incidents.
- Fulfilling the President's goals for community health center expansion.
- Enabling state insurance pools, association health plans and tax credits for workers unable to afford insurance.
- Supporting community-based approaches to closing the healthcare gap, particularly among racial and ethnic minority populations, including American Indians and Alaska Natives.
- Pushing for medical liability reform.

### Modernize Medicare and Medicaid

In 5,000 days, the Secretary sees a nation in which...

- Medicare and Medicaid are modernized to provide high-quality health care in a financially sustainable way.
- The beneficiaries of Medicare and Medicaid are cost-conscious consumers with expanded choices of plans and treatments.
- At their option, seniors and people with disabilities can be cared for in their home or community.
- Medicaid is flexible and nimble enough to tailor benefits to need, allowing millions more to obtain insurance.
- Medicare and Medicaid are viewed as leaders in the collaborative development and use of health information technology, quality measurement and pay for performance.

In the next 500 days the Secretary will concentrate on...

- Implementing the Medicare Modernization Act successfully by energizing broad participation, emphasizing preventive care, reaching out to those eligible for low-income subsidies and stimulating a competitive market.
- Modernizing Medicaid to ensure program dollars are used appropriately, to make consumers more cost-conscious, to tailor benefits to need, to allow home and community care for the elderly and persons with disabilities, and to stop inappropriate intergovernmental transfers.
- Creating workable methods of rewarding health providers for positive outcomes.
- Positioning HHS at the forefront of the health information technology interoperability movement.

**Advance Medical Research**

In 5,000 days, the Secretary sees a nation in which...

- Medications are safer and more effective because they are chosen based on the patient's personal characteristics.
- Research results more quickly benefit people and healthcare needs more quickly become research leads.
- Broad scientific advances measurably reduce the burden of all chronic diseases.
- Breakthroughs protect Americans from a broad range of biological, chemical, radiological and nuclear threats.
- Comprehensive, novel early prevention and detection strategies increase healthy life potential such that:
- Cancer is more preventable and curable,
- Obesity and its consequences, such as diabetes and heart and vascular diseases, are greatly reduced, and
- Causes of mental, neurological and behavioral diseases are better understood and managed.
- Interdisciplinary and interagency collaboration in scientific pursuits is the standard.

In the next 500 days the Secretary will concentrate on...

- Creating an integrated electronic network of privacy-protected population data, genetic information and medical records to accelerate discoveries that will define an individual's risk of disease, response to treatment and likelihood of a side effect.
- Building interdisciplinary research teams that combine skills and knowledge from the biological, physical and social sciences to yield biomedical insights that could not have been achieved by a single-discipline approach.
- Improving the clinical research network to advance better prevention, early diagnosis and treatment of disease.
- Implementing a comprehensive plan for obesity research that will maximize collaboration among HHS stakeholders.

**Secure the Homeland**

In 5,000 days, the Secretary sees a nation in which...

- State and local communities know how to help themselves and others in the event of a biological attack or flu pandemic.
- HHS and its partners can seamlessly and rapidly provide resources and public health personnel when needed anywhere in the United States.
- Surveillance of data in electronic health records provides early warnings of dangerous viruses or bioterrorism activities.

In the next 500 days the Secretary will concentrate on...

- Preparing for a potential H5N1 flu pandemic.
- Providing early warnings of naturally occurring and manmade threats through improved domestic and international surveillance.
- Developing a deployable mass casualty care capability to enhance medical surge capacity in response to a variety of threat scenarios.
- Aligning the force structure and deployment readiness of the Commissioned Corps with current needs.
- Improving the size and readiness of the Strategic National Stockpile and the ability to distribute it effectively.
- Enhancing emergency readiness of public health departments using risk-based investment.

**Protect Life, Family and Human Dignity**

In 5,000 days, the Secretary sees a nation in which...

- Children are protected from abuse and neglect.
- Seniors and persons with disabilities are cared for with dignity and respect.
- Faith and community-based groups are given equal access to government grants.

- Self-reliance and work are rewarded.
- Protection of life and adherence to sexual abstinence outside of marriage are values supported by public policies and taught to future generations.
- Family interests are protected and marriages strengthened.

In the next 500 days the Secretary will concentrate on...

- Promoting self-sufficiency and state flexibility in the reauthorization of TANF.
- Increasing the commitment to faith and community-based grants, including Access to Recovery.
- Improving Head Start coordination with state and federal departments of education.
- Supporting the First Lady's initiatives on Helping America's Youth and Women's Health and Wellness.
- Supporting a culture of life and family in international policies.

**Improve the Human Condition Around the World**

In 5,000 days, the Secretary sees a nation in which...

- The United States is recognized as a leader among nations for caring and compassion.
- HIV/AIDS is reduced all around the world.

In the next 500 days the Secretary will concentrate on...

- Supporting emerging democracies with health diplomacy.
- Implementing on schedule the goals of the President's Emergency Plan for HIV/AIDS relief and reauthorizing the Ryan White Care Act.
- Expanding the international network of early-warning infectious disease surveillance.

# Attachment B – CMS' Ongoing Work

### Attachment_B-Ongoing_Work_8-10-06.xls

# Ongoing Work at the Centers for Medicare & Medicaid Services

## "Keep the Trains Running"

While CMS is working toward accomplishing the objectives and initiatives in the CMS Strategic Action Plan, we are simultaneously performing activities that are needed to “Keep the Trains Running.” These activities include administrative functions (such as providing work space, resources, and training for CMS employees) as well as program functions (such as maintaining Medicare systems, updating codes and payment rates, paying providers timely, coordinating with the states and other stakeholders, and responding to beneficiary inquiries). These activities must continue as independent activities that implement or support CMS programs and/or be integrated into the accomplishment of our new initiatives.

Following is a list of much of our ongoing work, organized to address the five CMS Strategic Objectives as outlined in the Plan. This list is not 100% comprehensive. Rather it gives a general idea of the realm of ongoing work that CMS must accomplish on a daily basis to assure that our programs run smoothly, in addition to accomplishing our exciting new initiatives that are designed to achieve a modernized health care system for the 21st Century.

We will be using our Enterprise Portfolio Management (EPM) system to monitor progress on both our daily, ongoing work and our new initiatives. Working with CMS leadership and employees, we will continue to update this list on a semi-annual basis to capture the full scope of CMS work in the EPM inventory. Using the EPM, we will coordinate the initiatives and ongoing work in the Strategic Action Plan with the SES Performance Plans, and will use the EPM information to support the annual Organizational Assessment.

| Objective 1 | |
|---|---|
| **Work that maintains a skilled, committed, and highly motivated workforce** | **Is supported by our ongoing work** |
| Human Capital Management | In alignment with Department Priorities, GPRA, the President's Management Agenda, the CMS Strategic and Operational Plan, and the Budget, develop the Administrator's Performance Contract according to the Department's schedule. |
| | Coordinate the development of the SES Performance Plans to ensure they are aligned with the administrator's plan and include credible performance metrics. |
| | Prepare and submit the annual Organizational Assessment to HHS. |
| | Develop and submit timely performance and budget materials to the Department, OMB and Congress that clearly link the accomplishment of performance goals with the level of funding requested. |
| | Administer performance management and awards and recognition programs. |
| | Assure the appropriateness and integrity of all CMS contracting activities.<br>Continue to perform grants processing with the GATES grants processing system. |
| | Continuously improve budget formulation process, including converting the CMS budget compilation to a data base management system, providing a historical record and more flexible budget formulation scenarios. |
| | Develop a comprehensive Outreach and Recruitment Strategy to transform how we employ and deploy a high quality diverse workforce by placing the right people in the right jobs to most effectively perform the work of the organization and become an Employer of Choice. |
| | Administer recruitment, retention, and incentive programs to support the Agency's strategic recruitment. |
| | Provide New Employee Orientation to all new employees to prepare them for working in the CMS environment and provide them with general knowledge about all CMS business components. |
| | Deliver a variety of leadership development programs to staff and managers throughout the agency including but not limited to Proactive Leadership Skills (PLS) for non-supervisors at the journey and senior technical levels, Leadership in Context (LinC) for first-line supervisors, leadership coaching for individual managers and manager teams, Managing Performance Workshop for managers, and sponsorship for external leadership programs as funding permits. |
| | Provide career development services to individuals and groups including but not limited to career counseling, individual development planning, tuition assistance, career workshops, and mentoring. |
| | Manage and support quarterly all-manager meetings to keep managers abreast of current developments within CMS and the Department, and to provide briefings on topics of interest to managers and leaders. |
| | Provide consulting services to develop processes, tools and programs that encourage and strengthen organizational planning, problem solving, collaboration and partnership across components. (Organization Development) |
| **Objective 1** | |

| Work that maintains a skilled, committed, and highly motivated workforce | Is supported by our ongoing work |
|---|---|
| Human Capital Management (continued) | Support and promote the Agency's EEO and Workforce Diversity Recruitment Program; Promote the Agency's zero tolerance policies on harassment and discrimination. Comply with Agency EEO processes by addressing EEO complaints and requests for Reasonable Accommodation in an effective manner and in compliance with established timeframes. Ensure that all Center and Office Directors and Regional Administrators: 1) Comply with all EEO complaint and REasonable Accommodation processes and timelines; and 2) Complete all mandatory EEO training. |
| | Maintain an ongoing visible and credible commitment from CMS leadership to the Agency's Affirmative Employment and Workforce Diversity Program in accordance with the goals of Equal Employment Opportunity Commission Management Directive 715. Ensure Agency EEO and Civil Rights Policy is vigorously communicated and enforced by Agency management. |
| | Conduct agency-wide self-assessment to identify and eliminate barriers to equal employment opportunity in the workplace. |
| | Ensure the MLA supports mission accomplishment and is consistent with the future direction of the Agency and is properly administered. |
| | Annually submit a Competitive Sourcing Plan to HHS. |
| | Implement the HHS Department-wide HSPD-12 plan in accordance with the established schedule. |
| | |
| CMS Succession Plan | Develop a recruitment and development strategy based on succession planning data collected from all components within CMS and the Agency's goal to strengthen diversity. |
| | Work with all components to create component-driven succession plans. |
| | |
| Automation to Support Employee Work | Develop and maintain information systems that support Enterprise Portfolio Management, Federal Managers' Financial Integrity Act (FMFIA), and SES Performance Measurement. |
| | Establisn and maintain an Enterprise Portfolio Management architecture that aligns with the CMS Strategic Plan. |
| | Oversee follow-up of audit recommendations from external auditors and annual FMFIA compliance activities to evaluate impact on objectives, priorities, and organizational assessment. |
| | Working with components, facilitate adoption and acceptance of new Enterprise Portfolio Management (EPM) business processes, and assure that all agency projects are incorporated into the EPM system and that progress is updated regularly to provide progress reports to management. |
| | Assess projects and incorporate results into CMS' annual Organizational Assessment based on SES performance assessments. |
| | Provide training on CMS Enterprise Portfolio Management tools (e.g. Clarity Priority Project Tracker) to component users. |
| **Objective 1** | |

| Work that maintains a skilled, committed, and highly motivated workforce | Is supported by our ongoing work |
|---|---|
| Automation to Support Employee Work (continued) | Migrate all CMS internal training to the HHS Learning Portal for improved oversight, management and reporting. Participate with HHS University and other OPDIVs to upgrade the existing HHS Learning Management System to a more flexible and user-friendly system. |
| | |
| Other Ongoing Work That Supports Objective 1 | Provide Project Management, Risk Adjustment, and Process Improvement and Integration consulting and training to components to support effective and efficient operations. |
| | Model and analyze business processes to reduce redundancy and increase efficiency and productivity. |
| | Establish and maintain an accurate Inventory of Real Property for regular upload to the Departmental Automated Real Property Information System. |
| | Re-design the current reorganization process to streamline the process and improve collaboration and communication across components and the BHRC. |
| | Maintain historic preservation and environmental management programs in compliance with EO's, regulatory ad HHS guidance. |
| | Manage the CMS Library and associated resources to support the workforce's efforts to effectively perform the work of the organization. |
| | Participate in Departmental consolidation initiatives as required by HHS. |
| | Conduct extensive analysis in the areas of mail services; facilities management; property management; real property management; video and telephone management; environmental health and safety; reprographics; and printing. |
| | Provide centralized customer service by responding to service calls and performing preventive maintenance tasks. |
| | Plan and manage the critical high priority projects necessary to ensure the best workplace environment for all CMS employees. |
| | |

**Objective 2**

| Work that transforms our business processes to ensure accurate and predictable payments | Is supported by our ongoing work |
|---|---|
| | |
| Measuring and Reducing Payment Errors through Improper Payments Information Act (IPIA) Compliance | Manage MSP Coordination of Benefits and oversee the Coordination of Benefits Contractor. |
| | Process and issue timely on-going/recurring Medicaid state plan amendments. |
| | Develop technical assistance and systems support for the Medicaid Drug Rebate Initiative and Federal Upper Payment Limits System. |
| | Maintain systems for the collection, organization, review, and analysis of data relating to 1915(b) Medicaid managed care programs. |
| | Complete significant financial management reviews (FMRs) in 2006 as means of assuring the appropriateness of costs claimed by States. |
| | Ensure appropriate payments to states for Federal portion of Medicaid/SCHIP programs. |
| | Ensure coordination across CMS of Medicaid program, survey, and administrative budgets. |
| | Process and issue timely SCHIP state plan amendments. |
| | Effectively manage physician self referral exceptions. |
| | Identify and analyze payment issues to ensure that payments are appropriate and that they address the statutory requirements and intent. |
| | Improve provider knowledge of fee for service procedures and initiatives (coverage, payment policies). |
| | Maintain the Contractor Error Rate Testing Program (CERT) to estimate the amount of money improperly paid on a national level by the Medicare FFS program. |
| | Adjudicate all Provider Reimbursement Review Board, Medicare Geographic Classification Review Board and CMS Hearing Officer appeals. |
| | Publish CMS' priority regulatory initiatives in accordance with the schedules published in the Quarterly Provider Update. |
| | Periodically update codes and payment rates. |
| | |
| Expanding a Data Driven Approach to the Medicare Integrity Program (Medicare MIP) | Develop and continue programs of integrity, internal controls for QIOs. |
| **Objective 2** | |

| Work that transforms our business processes to ensure accurate and predictable payments | Is supported by our ongoing work |
|---|---|
| | |
| Implementing the Medicaid Integrity Program (MedicaidMIP) | Propose legislative, regulatory, and policy changes to assist States in identifying and preventing fraud and abuse and promoting consistency in fraud and abuse standards. |
| | Report on use and effectiveness of Medicaid Integrity Program funds. |
| | Provide support and assistance to states regarding Medicaid program integrity. |
| | Procure Medicaid integrity contractors. |
| | Update Comprehensive Medicaid Integrity Plan annually. |
| | Assure that systems fully comply with the Federal Information Security Management Accounting Standards. |
| | |
| Enhancing CMS' Financial Management Systems - HIGLAS | Sustain and improve efficiency of claims payment operation. |
| | |
| Updating Outmoded Coding Systems - ICD-10 | Begin strategy development and planning effort for ICD-10 implementation. |
| | |
| Implementing Private Sector Recovery Techniques | Maintain the Recovery Management and Accounting System (ReMAS) |
| | Manage Medicare Secondary Payer (MSP) recoveries. |
| | Oversee the Recovery Audit Contractor (RAC) demonstration. |
| | |
| Implementing the National Provider Identifier | Maintain and issue the National Provider Identifier (NPI). |
| | Respond to requests from health care providers for identifiers. |
| | Maintain the National Plan & Provider Enumeration System (NPPES). |
| | Maintain the Provider Enrollment Chain Ownership System (PECOS) and provide information as needed to administer benefits. |
| | |
| Ensuring Effective Grants Management | Employ information technologies in the award and administration of grants. |
| | |
| Transitioning to Medicare Administrative Contracting | Continue and extend the metrics-driven approach to assess agency performance in managing Medicare fee-for-service benefit administration, that focuses on effective governance through accountability and teamwork across CMS central and regional offices. |
| **Objective 2** | |

| Work that transforms our business processes to ensure accurate and predictable payments | Is supported by our ongoing work |
|---|---|
| | |
| Improving Electronic claims processing | Achieve integration between CBC and OIS operational systems to achieve good customer service and a strong base of program data. |
| | Comply with all appropriate health system standards including e-Rx, HIPAA (including NPI), and Consolidated Health Informatics (CHI) to ensure fullest interoperability between CMS and the rest of the health care system. |
| | Manage automated Medicaid and SCHIP budget and expenditure systems. |
| | Review and revise policy for Integrated Eligibility Systems. |
| | Develop Medicaid Statistical Information System (MSIS) requirements. |
| | |
| Reforming Payment Systems - IPPS, ASC, and OPPS | |
| | |
| Improving the Accuracy of Payment and Quality Measurement | Ensure our providers are paid accurately and timely. |
| | |
| Ensuring Provision of Services During Emergencies or Disasters | Develop and execute strategy/initiatives to ensure preparedness for response to major disasters. |
| | Maintain a high-degree of operational readiness and expertise in order to safeguard our critical assets and ensure Mission Continuity Assurance of CMS services |
| | Continuously educate, prepare, and provide protective services to CMS stakeholders. |
| | Meet FISMA, OMB, and Departmental security, certification and accreditation, and contingency planning requirements. |
| | Provide reliable emergency response; coordination of essential communications and payments; and protection of CMS' critical assets through physical security, personnel security and Continuity of Operation's programs. |
| | |
| Other Ongoing Work That Supports Objective 2 | Achieve integration between CBC and OIS operational systems to achieve good customer service and a strong base of program data. |
| | Review and revise policy for Integrated Eligibility Systems. |
| | Develop and update financial management policies and procedures. |
| | Continue current programs of internal controls. |
| | Process and issue timely on-going/recurring Medicaid state plan amendments. |
| | Implement a fully paperless contracting system for CMS. |
| | |

| Objective 3 | |
|---|---|
| **Work that transforms our business processes to ensure high value health care** | **Is supported by our ongoing work** |
| Information Technology Modernization | Improve IT management by continuing to develop Medicaid IT Architecture to continue to communicate CMSO's strategy to transform the MMIS to the States and IT industry. Work with OIS. |
| | Provide support for development of Electronic Health Records (EHR). |
| | Fulfill E-Gov alignment milestones. |
| | Give practitioners and providers advice on making care more effective, particularly including the promotion of effective electronic health systems. |
| | Work with OESS to provide leadership in electronic medical records as it applies to standardization of processes, quality initiatives, access to information and billing. |
| | Provide ongoing interpretation, outreach, technical assistance on HIPAA, CHI, Prescribing, and other standards to CMS components and the health care industry to advocate and assure the use of standards. |
| | Direct and Support the CMS Health Steering Committee, focusing agency activities on priority areas including Integrated Data Strategy, Electronic Health Record Implementation, Providing beneficiaries and providers with access to data. |
| | Develop and maintain policies and procedures to ensure a sustainable CMS e-health infrastructure, including E-authentication, an Integrated Data Strategy, and standards implementation. |
| | Continue maturation of the CMS Enterprise Architecture through the development of major business lines and business process models for CMS investments. |
| | Continue the development of an Integrated Data Repository that will lead to more consistent, accurate, reliable, and timely data to serve the needs of CMS and critical partners. |
| | Continue identifying ways of integrating strategic planning with key business functions to include capital planning, budgeting, and enterprise architecture. |
| | Continue to improve internal controls of the capital planning and investment management process. |
| | Support the Secretary's AHIC process for building HIT infrastructure and standardization. |
| | Work with AHRQ on the development of outcome measures and quality indicators for the HCBS program under the new 1915(i) optional State plan benefit. |
| | |

| Objective 3 | |
|---|---|
| **Work that transforms our business processes to ensure high value health care** | **Is supported by our ongoing work** |
| Medicare Prescription Drug Program | Collaborate with States, Regions, and providers to implement Requirements Governing the Use of Restraint and Seclusion in Patient or Residential Care Facilities that Receive Federal Funding. |
| | Oversee identification and auto-enrollment of all dual eligible beneficiaries into prescription drug plans, including the resolution of all related policy issues. |
| | Maintain Part D operational guidance/requirements and review process (application/renewal, marketing, formulary, etc.). |
| | Maintain integration of Medicare Prescription Drug, Medicare Advantage and Employer product management to ensure parallel and consistent operation across Agency including Regional Offices. |
| | Perform actuarial review of PDP and MA bid submissions, including separate MA drug plan submissions and determinations of actuarial equivalence (to implement Prescription Drug and Medicare Advantage Programs). |
| | Work with other agency components, ongoing tracking of Medicare drug benefit savings, benefits, enrollment, and external reports. |
| | Continue to effectively manage rollout of MMA prescription drug and MA plans and achieve basis for effective long term management. |
| | Provide technical support and guidance for Medicare Advantage industry covering applications, bid preparation, contracts, Special Needs Plans, etc. |
| | Oversee MMA policy development and the resolution of issues related to Medicare (Parts A, B, C and D eligibility (including low income subsidy), enrollment and appeals. |
| | Develop and disseminate guidance to health plans on Part C and Part D eligibility, enrollment and appeals rules. |
| | Coordinate program evaluations of the Medicare Prescription Drug Benefit |
| | Coordinate program evaluations of the Medicare Advantage Program |
| | |

| Objective 3 | |
|---|---|
| **Work that transforms our business processes to ensure high value health care** | **Is supported by our ongoing work** |
| | Improve the survey process, proficiency testing, and informational infrastructure for CLIA. |
| | Train survey and certification surveyors. |
| | Promote the fiscal integrity and transformation of Medicare and Medicaid by projecting program costs and revenues for the annualMedicare Trustees Report, President's Budget, Mid-Session Review of theBudget, and CMS Annual Financial Statement ("CFO Report"). |
| | Provide accurate, authoritative, and responsive actuarial, economic, and other technical assistance (provided by OP) to policy makers in CMS, HHS, OMB, the White House, the Congress, and to the Board of Trustees of the Medicare trust funds. |
| | Support Medicare and Medicaid legislative and regulatory policy development by providing actuarial estimates of financial impacts of proposals, and by evaluating their technical feasibility and expected effectiveness. In particular, develop actuarial estimates. |
| Long-Term Solvency | Promote the fiscal integrity and transformation of Medicare and Medicaid by projecting program costs and revenues for the Medicare Trustees Report, President's Budget, and CMS Annual Financial Statement ("CFO Report"). |
| | Evaluate the financial status of Medicare, Medicaid, and other CMS programs. Design and develop long-range models of the healthcare economy in the context of the overall national economy, to better understand interactions among sectors and in support. |
| | As baseline for comparison to Medicare and Medicaid, and in support of initiatives to improve health for all Americans, prepare comprehensive National Health Expenditure Accounts and projections. |
| | Determine statutory program amounts for Medicare and Medicaid, including (1) Part A monthly premium, inpatient hospital deductible and coinsurance amounts, and skilled nursing facility coinsurance amount; (2) Part B standard and income-related monthly premiums. |

| Objective 3 | |
|---|---|
| **Work that transforms our business processes to ensure high value health care** | **Is supported by our ongoing work** |
| | |
| Medicaid Reform Roadmap | Collaborate with States, Regions, and external organizations to implement the Medicaid/SCHIP Quality Strategy. |
| | Collaborate with States, Regions, and providers to implement survey procedures and interpretative guidelines for the Requirements for Approval and Re-Approval of Transplant Centers To Perform Organ Transplants. |
| | Provide States with flexibility through the approval of their application for 1115 Demonstrations and 1915(b) Waivers with parameters that could include reducing uninsured, promotion of personal responsibility, budget neutrality and program outcomes evaluation. |
| | Improve health care quality across Medicaid and SCHIP in accordance with GPRA Plan. |
| | Collaborate with States, Regions, and providers to implement new requirements in all nursing homes. |
| | Encourage State adoption of benchmark coverage under DRA. |
| | Conduct policy analysis and development activities with other CMS components regarding long term care reform, post acute care reform, transparency initiatives, value project and Medicare drug benefit. |
| | Improve the quality of the survey of nursing homes and update interpretative guidance for surveyors. |
| | Develop interpretive guidance for the new ESRD regulation. |
| | Improve the survey process for hospitals. |
| | |
| The New Orleans Health System | |
| | |
| Prevention and Quality Care | Provide support for non-Medicare, vulnerable populations as assigned (undocumented immigrants, disaster victims, and EMTALA). |
| | Implement and evaluate the BIPA Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities. |
| | Conduct the Medicare Current Beneficiary Survey to assist policy makers and researchers in monitoring and evaluating the Medicare program and produce statistics and linked data files. |
| | Revise Clinical Trials Policy to allow quicker access to medical technologies/innovations. |
| | Produce the annual MAX (Medicaid Analytic eXtract ) to support internal and external research analyses. |
| | Implementation and Evaluation of Low Vision Rehab Demonstrations. |
| | Implement and evaluate the MMA demonstration project for Consumer Directed Chronic Outpatient Services. |
| | Continue demonstrations and evaluations of Medicare Health Support Pilot, High Cost Beneficiary, ESRD Disease Management to test effectiveness of coordinated care models. |
| | Evaluate Part D Payment Demonstration. |
| | Coordinate with Department's Research Coordination Council in developing CMS research agenda. |

| Objective 3 | |
|---|---|
| **Work that transforms our business processes to ensure high value health care** | **Is supported by our ongoing work** |
| Prevention and Quality Care, continued | Prepare and submit Reports to Congress as required. |
| | Plan, implement, and maintain the CMS research portfolio. |
| | Publish issues of the Health Care Financing Review in season. |
| | Support the efforts of the Administrator, Deputy Administrator, and component to establish, clear, and promote policies in the area mentioned by managing the decision making process to include demonstrations and quality/performance related regulations. |
| | Collaborate with States, Regions, and providers to implement the Conditions for Coverage for Organ Procurement Organizations (OPOs). |
| | Manage and maintain the Coverage with Evidence Development process. |
| | Keep conditions of participation/conditions for coverage regulations up-to-date to assure they reflect current practice, encourage continuous quality improvement, and reduce regulatory burden where possible. |
| | Maintain searchable web resource that tracks all documents related to the National Coverage Determination (NCD) review process, that contains all final NCDs, and provides for electronic submission of public comments. |
| | Maintain responsiveness to the public, providers, and Congress by meeting or exceeding the timeframes outlined by Congress for publishing National Coverage Determinations decision memorandums. |
| | Coordinate policy analysis with CBC, CMM, CMSO, OCSQ and OL |
| | Maintain the multi-pronged Medicare outreach and awareness campaign at the national, regional, and local levels to ensure that people with Medicare are aware of their rights, benefits and health care options. |
| | Develop educational materials designed to foster understanding and support choice by preparing and distributing publications, direct mailings, and plain language fact sheets to strengthen communications of information to people with Medicare. |
| | Develop publications and related promotional materials designed to enhance the Agency's health promotion and disease prevention efforts. |
| | Develop improved patient-centered consumer-based materials. |
| | Continue to support effective prevention with the flu campaign, mammography campaign, etc. |
| | Develop and conduct preventive care demonstrations such as colorectal cancer screening services. |
| | Continue provider education campaigns on prevention. |
| | Manage integrated media affairs/external relations and operations between DC and regional media affairs staff. |
| | Maintain campaign infrastructure and capacity in regions for purposes of promoting open season, prevention and quality health care initiatives. |
| | Ensure maximum use of technology (i.e., Bacon’s system) for all aspects of OEA, especially media. |

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| | Developing a patient assessment and cost collection tools for Post Acute Care. |
| | Designing a large-scale implementation of new assessment and cost collection tools. |
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| **Objective 3** | |
| **Work that transforms our business processes to ensure high value health care** | **Is supported by our ongoing work** |
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| Pay for Performance | Publish quality measurements and information (includes both the beneficiary audience and the professional/provider/purchaser audience). |
| | Expand CMS's public promotion of quality improvement and transformation of the healthcare system. |
| | Continue to strengthen the Quality Network Exchange (Qnet) which allows QIOs and providers to develop and share information on health care quality and best practices . |
| | Continue to strengthen Health Care Quality Improvement Systems (QIES and OSCAR) to support quality oversight and monitoring of health care services and settings. |
| | Implement and evaluate hospital gainsharing demonstration. |
| | Implement pay-for-performance in priority settings: hospitals, physician practices, home health agencies, nursing homes, and dialysis facilities. Consider pay-for-performance demonstrations in the home health, nursing home, and dialysis facility settings. Include cost of care measures in pay-for-performance initiatives. |
| | Include measures of appropriate preventive care in pay-for-performance initiatives. |
| | Oversee the 646 Medicare Health Care Quality Demonstration to test methods to improve quality, patient safety, efficiency, and reduce unwarranted variations in medical practice. |
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| Objective 4 | |
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| **Work that transforms our business processes to empower confident, informed consumers** | **Is supported by our ongoing work** |
| Personal Health Records (PHR) | Ensure a coordinated and consistent approach to individual privacy rights and protections through the executive leadership of CMS' Beneficiary Confidentiality Board (BCB). |
| | Address beneficiary privacy issues associated with SSNs and health identification numbers. |
| | Implement the secure transmission of Medicare information to Personal Health Records. |
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| Electronic Prescribing | |
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| Beneficiary Contact Centers | Provide Ombudsman outreach systems to encourage and inform beneficiaries how to make better choices. |
| | Improve Medicare Ombudsman customer service performance based on data and trends analysis. |
| | Use CQI to ensure Medicare Ombudsman program improvement recommendations are implemented. |
| | Continue to provide information and understanding of Medicare policies via external communications with advocates and beneficiaries. |
| | Conduct ongoing consumer research assessment to improve our communication efforts. |
| | Provide local outreach and assistance and personalized counseling to people with Medicare and their caregivers. |
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| Money to follow the person (MFP) in every State Medicaid program | |
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| Up-to-date Medicaid benefit choices and personal consumer responsibility about health care choices | Conduct policy analysis and development activities with other CMS components regarding long term care reform, post acute care reform, transparency initiatives, value project and Medicare drug benefit. |
| | Increase the number of people who have the option to self-direct services, through the new self-directed personal care State plan option, the new HCBS State plan option, and HCBS waivers. |
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| Medicare Health Support Pilot Program | |

| Objective 4 | |
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| **Work that transforms our business processes to empower confident, informed consumers** | **Is supported by our ongoing work** |
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| Pandemic Flu | |
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| Availability of accurate and comparative information for beneficiaries - Transparency | Inform and educate federal grantees, including state and local officials, who administer funds about the requirements of the Equal Treatment and Charitable regulations by developing standard language to include in the terms and conditions of all new grants. |
| | Regional office continue to work with states, providers, and other partners to ensure that health care is financially accessible to everyone. |
| | Develop transparency collaborations to ensure consumers get the best quality care at the best price. Develop platforms that allow consumers to know in advance what their medical options are, the quality and expertise of physicians and hospitals in their area, and what their medical care will cost them. |
| | Continuously improve Compare websites for hospitals, home health agencies, nursing homes, and dialysis facilities. |
| | Maintain the Research Data Assistance Center to help researchers and policy makers in obtaining and using Medicare and Medicaid data. |
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| Quality information on disease prevention and management - Transparency | Maintain and expand beneficiary E- services such as access to personalized Medicare information and quality of care reminders through the my.medicare.gov and 1-800 IVR. |
| | Support the quality initiatives, including public reporting of performance measures, by designing, implementing, and reporting on consumer satisfaction with different segments of the health delivery system. |
| | Develop quality measures for nursing home staffing and improve the comprehensiveness of staffing information on Nursing Home Compare. |
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| Medicare Advantage | Continue Performance Assessment (PA) of Medicare Advantage plan performance, and expand to include Part D plans. |
| | Oversee the "One-Third Audits" - financial audit of Part D prescription drug plans and one third of all reviews of the MA bids. |
| | Develop and maintain survey and certification systems. |
| | Maintain and continue to improve the payment systems used to pay providers in accordance with MMA requirements for Part C and Part D. |
| | Support payment policy development and implementation for Part C and Part D. |
| | Conduct the Health Outcomes Survey to provide information on the quality of care in Medicare Managed Care Organizations. |

| Objective 4 | |
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| **Work that transforms our business processes to empower confident, informed consumers** | **Is supported by our ongoing work** |
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| Data systems capacity for Baby Boomers | |
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| Beneficiary outreach and education on coverage, services and privacy | Continue development and deployment of the Virtual Call Center Strategy (VCS) to update and standardize call center technologies such as the Next Generation Desktop (NGD), the Interactive Voice Response (IVR) applications and Computer Telephone Integration. |
| | Continue to add features and users to my.medicare.gov to increase the number of transactions conducted online. |
| | Educate the public on changes to the Medicare and Medicaid programs more effectively through implementation of technology improvements via the CMS public websites. |
| | Continue to improve the efficiency and effectiveness of Medicare beneficiary inquiries technology and operations. |
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| Other Ongoing Work That Supports Objective 4 | Administer Medicare's beneficiary appeals process. |
| | Through a research data distribution center contract, provide CMS data to external organizations to support health services research; modify plans to incorporate chronic care and Part D data. |
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| Objective 5 | |
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| **Work that transforms our business processes to develop and sustain collaborative partnerships** | **Is supported by our ongoing work** |
| Internal Customer Service | Expand CMS contracting opportunities for small businesses. |
| | Establish incentives for cross-agency collaboration and partnering on projects and IT investments. |
| | Maintain electronic databases available within CMS and externally that provide information on research and demonstration projects throughout the Agency. |
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| External Partners | Partner with health plan industry trade associations to help ensure PDP, MA-PD, MA and Employer group organizations understand and comply with CMS program requirements. |
| | Collaborate with Administration, Congress, policy experts and key stakeholders to achieve legislative support for CMS programs and operations; to ensure strong regulatory and external affairs support for CMS programs and operations; and, to ensure strong policy support for CMS strategies, programs and operations. |
| | Produce publications summarizing CMS statistics and analyzing program developments, for use by leadership within CMS, in the Department and Congress. |
| | Provide strong regional public affairs presence. |
| | Partner with Accreditation Organizations to develop a process to exchange complaint information with accrediting organizations. |
| | Collaborate with post-acute care industry to provide person/patient-centered care. |
| | Provide training on relationship management to maximize grassroots and grassroots visibility and activities of CMS. |
| | Continue to develop and support partners in the beneficiary and provider community at the local level. |
| | Support and expand partnerships with FBO's and other community organizations to help educate and assist people with Medicare on program issues. |
| | Monitor and report on quality performance in consumer assistance programs. |
| | Work with advocates and partners in providing feedback to CMS on beneficiary needs. |
| | Collaborate with performance/quality improvement organizations, persons & providers to develop nationwide PI/QI strategy/initiatives. |
| | Regional offices partner with providers, payers, and other organizations to create health care that promotes choice at the individual level of care. |
| | Collaborate with ONCHIT, providers, other payers, vendors develop/executes strong “virtual health (information) system.” |
| | Collaborate with States, HRSA, persons, providers and other payers to provide extra support to most vulnerable persons. |
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| | Support, cooperate and coordinate with relevant outside groups (ONC, NCVHS, AHIC, WEDI, etc). Provide staffing, develop joint projects, perform outreach to important e-health organizations to execute CMS/ONC e-Health priorities. |
| | Utilize the Medicare Coverage and Advisory Committee (MCAC) to supplement internal expertise and provide a public forum to support CMS policies for national coverage. MCAC should also support the Agency's commitment to a public, transparent decision making. |
| | Work with internal and external partners to assure adequate and appropriate information mechanisms in place to communicate vital information. |
| | Work with ASPE and AoA to educate individuals about the need to plan for LTC and make it and part of retirement planning. |
| External Partners, continued | Establish and validate consumer assistance performance measures to facilitate improvements across care settings. |
| | Collaborate with quality alliances, including the Hospital Quality Alliance (HQA), Ambulatory Care Quality Alliance (AQA), Pharmacy Quality Alliance (PQA), and National Quality Forum (NQF), among others. |
| | Collaborate with medical socities, like the American Medical Association (AMA) and medical specialties, to further quality initiatives. |
| | Continue sharing Part B data (and expand to Part D data if granted authority) with the FDA and AHRQ in support of post market drug surveillance studies and quality improvement activities for patients with chronic illnesses. |
| | Implement the Long-Term Care Partnership State Plan Option Provisions in the Deficit Reduction Act. |
| | Support faith-based community partnerships in providing effective health and human services by insuring that all relevant outreach efforts have a faith based component. |

| Objective 5 | |
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| **Work that transforms our business processes to develop and sustain collaborative partnerships** | **Is supported by our ongoing work** |
| Intergovernmental Affairs | Collaborate with FDA, NIH, and CDC, as opportunities present. |
| | Collaborate with HHS, FEMA, States ensure prep for and response to major disasters. |
| | Collaborate with AHRQ, ASPE and other external operations doing research and analysis to ensure strong research, demonstration and information. |
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| Legislative/Congressional Affairs | |
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| State Health Insurance Assistance Program (SHIPs) | Increase the number of individuals transitioned from institutions to communities. |
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| Informed Provider Community | |
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| Other Ongoing Work That Supports Objective 5 | |
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