CMS Online Performance Appendix
to the
FY 2009 CMS Congressional Justification

Online Performance Appendix

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Introduction

The Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

The Centers for Medicare & Medicaid Services Congressional Justification and Online Performance Appendix can be found at http://www.cms.hhs.gov/PerformanceBudget/

Summary of Measures and Results Table
Centers for Medicare & Medicaid Services

FY	Total Targets	Results Reported		Targets			
					Not Met		
		Number	%	Met	Total	Improved	% Met
2002	59	59	100%	45	14	9	76%
2003	63	63	100%	50	13	7	79%
2004	56	56	100%	46	10	6	82%
2005	49	49	100%	39	10	6	80%
2006	45	45	100%	42	3	1	93%
2007	47	35	74%	31	4	3	89%
2008	50	n/a	n/a	n/a	n/a	n/a	n/a
2009	51	n/a	n/a	n/a	n/a	n/a	n/a

Medicare

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirement										
MCR 10.1	Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Fiscal Interme-diaries	99.5%	99.9%	95%	99.8%	95%	99.8%	95%	95%	N/A
MCR 10.2	Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Carriers	99.7%	98.4%	95%	99.5%	95%	99.0%	95%	95%	N/A
Long-Term Objective: Implement Medicare Contracting Reform										
MCR 13.1	Award Medicare FFS Workload to the MACs	N/A	De-livered Report to Con-gress	Award 8.8%	Award 9.1%	Award 54.1%	Award 22.2%	Award 79.6%	Award 100%	N/A
MCR 13.2	Implement FFS workload to the MACs	N/A	N/A	N/A	N/A	Implement 8.8%	Imple-ment 9.1%	Implement 54.4%	Imple-ment 100%	N/A
Long-Term Objective: Implement the Medicare Prescription Drug Benefit										

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 3.1a	Beneficiary Survey Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006	N/A	N/A	49.4%	Goal met 67%	62%	Goal met 63%	63%	64%	N/A
MCR 3.1b	Beneficiary Survey Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	N/A	N/A	52.5%	Goal met 69%	64%	Goal met 69%	65%	66%	N/A
MCR 3.1c	Beneficiary Survey Percentage of bene-ficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	N/A	N/A	28.4%	Goal met 50%	45%	Goal met 68%	46%	47%	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 3.2	Program Management/ Operations	N/A	N/A	Implement a Part D Claims Data system, oversight system, and contractor management system	Goal met	Publish Part D sponsor performance metrics on the Medicare Prescript. Drug Plan Finder (MPDPF) tool	Goal met	Publish the 2007 report card of Part D plan sponsor performance	Add "Patient Safety" measures and refresh all report card measures	N/A
MCR 3.3	Enrollment Increase percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources	N/A	N/A	N/A	90% baseline	N/A	Feb-08	N/A	TBD	N/A
Long-Term Objective: Maintain CMS' Improved Rating on Financial Statements										
MCR 12	Maintain an Unqualified opinion	Goal met	Goal met	Maintain	Goal met	Maintain	Goal met	Maintain	Maintain	Maintain (2010)
Long-Term Objective: Decrease the Prevalence of Restraints in Nursing Homes										
MCR 4	Decrease the Prevalence of Restraints in Nursing Homes	7.3%	6.6%	6.4%	6.1%	6.2%	Feb 08	6.1%	6.0%	5.9% (2010)
Long-Term Objective: Decrease the Prevalence of Pressure Ulcers in Nursing Homes										
MCR5	Decrease the Prevalence of Pressure Ulcers in Nursing Homes	8.7%	8.5%	8.8%	8.2%	8.6%	Feb 08	8.5%	8.5%	N/A
Long-Term Objective: Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive										

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 1.1a	Percent of persons with Medicare Advantage (MA) Plans report they usually or always get needed care right away as soon as they thought they needed it	N/A	N/A	Develop survey	Goal met (Trend) – 89.9%)	Set baselines/ targets	Goal met	90%	90%	N/A
MCR 1.1b	Percent of persons with Medicare Fee-for-Service (MFFS) report they usually or always get needed care right away as soon as they thought they needed it	N/A	N/A	Develop survey	Goal met (Trend) – 90.8%)	Set baselines/ targets	Goal met	90%	90%	N/A
MCR 1.2a	Percent of persons with MA Plans report that it is usually or always easy to use their health plan to get the medicines their doctor prescribed	N/A	N/A	Develop survey	Goal met (Trend – 92.7%)	Set baselines/ targets	Goal met	91%	91%	N/A
MCR 1.2b	Percent of persons with MFFS and a stand alone drug plan report it is usually or always easy to use their Medicare prescription drug plan to get the medicines their doctor prescribed	N/A	N/A	Develop survey	Goal met (Trend – 91.0%)	Set baselines/ targets	Goal met	90%	90%	N/A
Long-Term Objective: Improve Medicare's Administration of the Beneficiary Appeals Process										

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 2.1	Medicare Prescription Drug Program: Enhance Medicare Appeals System (MAS) functionality and support major maintenance releases	N/A	N/A	N/A	N/A	N/A	N/A	Enhance MAS function-ality and support major main-tenance releases	Enhance MAS function-ality and support major main-tenance releases	N/A
MCR 2.2	Medicare Advantage: Enhance MAS functionality and support major mainten-ance releases	Goal Met Began col-lection of IRE data	Goal Met Began integ-rating IRE data repor-ting into the MAS func-tionality	Fully inte-grate Inde-pendent Review Entity data report-ing into the MAS	Goal Met	Enhance MAS function-ality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases	Enhance MAS function-ality and support major main-tenance releases	N/A
MCR 2.3	Fee-for-Service: MAS func-tionality and support major main-tenance releases	Goal Met Devel-oped the first incre-ment of the MAS	Goal Met Devel-oped the second incre-ment of the MAS	Develop the third incre-ment of the MAS	Goal Met	Enhance MAS func-tionality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases	Enhance MAS function-ality and support major main-tenance releases	N/A
Long-Term Objective: Improve Beneficiary Telephone Customer Service										
MCR 9.1a	Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act	96.07%	98%	90%	93%	90%	95%	90%	90%	N/A
MCR 9.1b	Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	99.21%	98%	90%	97%	90%	97%	90%	90%	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 9.1c	Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	95.36%	98%	90%	94%	90%	94%	90%	90%	N/A
MCR 9.2	Maintain and continue to develop Virtual Call Center Strategy (VCS) initiatives for handling beneficiary inquiries	N/A	Goal Met Maintained Quality Standards from the previous fiscal year.	Maintain and continue to develop VCS initiatives for handling bene. inquiries	Goal Met	Maintain and continue to develop VCS initiatives for handling bene. inquiries	Goal Met	Maintain and continue to develop VCS initiatives for handling bene. inquiries	Maintain and continue to develop VCS initiatives for handling bene. inquiries	N/A
Long-Term Objective: Increase the Use of Electronic Commerce/Standards in Medicare										
MCR 11.1a	Electronic Media Claim Rates for FIs	Goal Met 97.82%	Goal Met 98.52%	97%	99.46%	99%	99.68%	N/A	N/A	N/A
MCR 11.1b	Electronic Media Claim Rates for Carriers	Goal Met 85.79%	Goal Met 88.33%	85%	91.64%	92%	94.74%	N/A	N/A	N/A
MCR 11.2a	Electronic Remittance Advice Rates for FIs	Goal Met Completed baseline data	Goal Met Completed analysis of baseline data	50%	53.27%	55%	58.14%	59%	60%	N/A
MCR 11.2b	Electronic Remittance Advice Rates for Carriers	Goal Met Completed baseline data	Goal Met Completed analysis of baseline data	35%	32.96%	37%	44.02%	45%	46%	N/A
MCR 11.3a	Electronic Claims Status for FIs	Goal Met Completed baseline data	Goal Met Completed analysis of baseline data	Increase the FY 2005 level by 10%	Goal Met 6,936,960	Increase the FY 2006 level by 5%	Goal Met 9,918,274	N/A	N/A	N/A
MCR 11.3b	Electronic Claims Status for Carriers	Goal Met Completed baseline data	Goal Met Completed analysis of baseline data	Increase the FY 2005 level by 10%	Goal Met 2,835,340	Increase the FY 2006 level by 5%	Goal Met 6,347,560	N/A	N/A	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 11.4	Eligibility Query	Goal Met Completed baseline data	Goal Met Began collection of eligibility query baseline data following completion of eligibility query and response transaction	Complete collection of eligibility query baseline data following Internet implementation of eligibility query and response transaction	Goal Met	Increase the number of Internet users to 1,000	Goal Met Internet users: 1,065	N/A	N/A	N/A
MCR 11.5	Electronic Funds Transfer (EFT)	Goal Met Completed baseline data	Goal Met Completed analysis of baseline data	Reduce paper check remits by 40% and FI paper check remits by 10%	Goal Not Met	Obtain 100% EFT for all new providers; and convert remaining physicians, suppliers, and providers not currently using EFT	Goal Met	N/A	N/A	N/A
Long-Term Objective: Mature the Enterprise Architecture Program										

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MCR 14	Mature the Enterprise Architecture (EA) Program	Goal met Con-tinue ma-turing the EA	Goal met Con-tinue ma-turing the EA	Continue maturing the EA	Goal Met	Continue maturing the EA	Goal Met	Continue maturing the EA 1) Establish manage-ment practices, process and policies to develop and oversee EA. 2) Expand the EA Repository 3) Integrate EA with CMS' CPIC process	Mature EA Program 1) Establish manage ment prac-tices, process and policies to develop and oversee EA. 2) Expand the EA Reposi-tory 3) Integrate EA with CMS' CPIC process	N/A
Long-Term Objective: Strengthen and/or Maintain Diversity at all Levels of CMS										
MCR 15	Increase representa-tion of EEO groups in areas where agency participation is less than the National and/or Federal baseline comparing the CMS workforce with the 2000 National Civilian Labor Force	In-crease	Increase	Increase	Goal met	Increase	Goal met	Increase	Increase	N/A

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
MCR6	Percentage of States that survey Nursing Homes at least every 15 months	N/A	Baseline 66%	N/A	N/A	N/A	N/A	80%	85%
MCR7	Percentage of States that survey HHAs at least every 36 months	N/A	Baseline 42%	N/A	N/A	N/A	N/A	70%	75%
MCR8	Percentage of States for which CMS makes a Non-delivery Deduction from the State's subsequent year survey and certification funds.	N/A	Baseline 6%	N/A	N/A	N/A	N/A	70%	75%
Appropriated Amount ($ Millions)		**$301,696**	**$342,502**	**$389,740**		**$441,789**		**$465,931**	**$498,761**

MCR10: Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements

The Social Security Act, sections 1816 (c)(2) and 1842 (c)(2) establish the mandatory timeliness requirements for Medicare claims payment to providers of services. As a result, Medicare intermediaries, carriers, and Medicare Administrative Contractors (MACs) are required to pay 95 percent of clean electronic media bills/claims between 14 to 30 days from the date of receipt.

Since CMS has identified bills/claims-processing as a priority area, Medicare contractors are required to maintain the statutory level of bills/claim-processing timeliness performance while strengthening their ability to deter fraud and abuse in the Medicare program. Medicare contractors have been able to consistently exceed the target for timely claims processing by continually improving the efficiency of their processes. Another factor in their ability to exceed the target is the conversion to standardized processing systems. CMS has also provided contract incentives to reward contractors for performance exceeding statutory requirements.

CMS has exceeded its FY 2007 target for Medicare intermediaries (95 percent) and carriers (95 percent), by reaching levels of 99.8 percent and 99.0 percent, respectively. The FY 2009 target remains to maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims in a millennium compliant environment. Continued success of this measure results in the assurance of timely claims processing for Medicare beneficiaries and providers.

MCR13: Implement Medicare Contracting Reform

Historically, nearly all of the Medicare fee-for-service (FFS) Fiscal Intermediary (FI) agreements and Carrier contracts were initiated on a non-competitive basis, and the original contracting provisions contained in the Social Security Act allowed CMS to renew the contracts annually based on satisfactory contract performance. The original Medicare legislation specified requirements for an entity to serve as an FI or carrier, limiting CMS' flexibility in using full and open competition to procure new contracts or shift work.

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established Medicare Contracting Reform. The provision directs CMS to replace the current Medicare FI and Carrier contracts, using competitive procedures, with new Medicare Administrative Contractor (MAC) contracts by October 2011. The new MAC contracts may be renewed annually based on performance for a period of 5 years, but they must be re-competed every 5 years. The introduction of competitive contracting is expected to improve the operating efficiency of Medicare FFS claims operations, generating administrative savings. CMS also expects that Medicare Contracting Reform will yield $1.5 billion in trust fund savings through FY 2011.

For FY 2007, CMS implemented 9.1 percent of the FFS workload (five MAC contracts). Also, CMS awarded an additional two contracts to MACs, for a total award of 22.2 percent of the FFS workload, which was 31.9 percentage points (five MAC contracts) below the target. Two additional MAC contracts were awarded during the first quarter of FY 2008, but their implementation has been delayed due to bid protests. CMS expects to award three additional MAC contracts during the second quarter of FY 2008, which will fulfill the original FY 2007 target. CMS expects to meet the FY 2008 target with the additional MAC awards that remain scheduled for the latter part of FY 2008.

The slippage in the FY 2007 award schedule was largely due to the complexity and magnitude of these MAC procurements and the number of submitted bids exceeding Agency projections. To address these challenges, CMS has implemented process improvements and added resources (contract officers/specialists, panels, support services contractor) to better manage these procurements. In addition, the FY 2008 and FY 2009 targets have been adjusted in keeping with CMS' current Integrated EDC (Enterprise Data Center)-MAC-HIGLAS (Health Care Integrated General Ledger Accounting System) Schedule. The factors causing current schedule delays include bid protests, staffing constraints, performance and capacity issues at EDCs, and legacy contractor non-renewals.

The delays in MAC awards do not impact beneficiary receipt of Medicare benefits. Providers may be served by legacy fiscal intermediaries or carriers for a slightly longer period than originally anticipated, but this should be relatively transparent to them. CMS also believes that the present delays in MAC awards, provided CMS' mitigating actions are effective, will not have a material impact on anticipated program savings.

MCR3: Implement the Medicare Prescription Drug Benefit

CMS' prescription drug benefit measure addresses three aspects of the benefit: (1) a beneficiary survey measuring knowledge of the benefit; (2) a management/operations component involving Part D sponsor performance metrics published on the Medicare Prescription Drug Plan Finder (MPDPF) tool; and (3) an enrollment component measuring increase of Medicare beneficiaries with prescription drug coverage from Part D or other sources which will start reporting in FY 2009.

During the initial enrollment period and the first open enrollment period, we implemented intensive outreach and education campaigns, with associated media activities. As a result, CMS was able to meet its FY 2007 target for this measure. Under the Beneficiary Survey component of this measure, meeting the first target, which reflects global awareness that drug coverage is available to Medicare beneficiaries, indicates that pertinent outreach and education activities have been effective. In meeting the second target, which assesses specific awareness that costs can vary by Part D plan, and the third target, which assesses specific awareness that formulary can vary by Part D plan, there is a clear indication that the open enrollment outreach and education campaign has been very effective.

CMS faces a challenge in continuing to increase beneficiary knowledge about Part D, given that 2009 will be the fourth open enrollment year, and fewer beneficiaries are likely to be interested in Part D messages. In subsequent years, primarily new enrollees will be motivated to become educated regarding Part D to make an initial choice, and they will be doing so with less intense communication activities directed toward them. Since most existing beneficiaries will be increasingly less likely to rethink their Part D plan choices, and subsequently forget what they know about the program, the likely result is a decline, and eventual plateau, in Part D knowledge across all beneficiaries. CMS will continue to engage in communication activities to try to counter this decline and will continue to track beneficiary knowledge to gauge the effectiveness of these efforts.

CMS continues to work with Part D plans and other stakeholders to improve program operations and public knowledge of this valuable program. CMS wants to ensure that beneficiaries receive the best prescription drug coverage available and they have the data necessary to make the most informed decision about plan selection. To assist beneficiaries making enrollment decisions for the FY 2007 plan year, CMS collected, analyzed and published the results of performance analysis on the MPDPF tool, thus meeting its Program Management/Operations target for FY 2007. The MPDPF offers beneficiaries useful information regarding performance metrics such as: Telephone Customer Service, Complaints, Appeals, Information Sharing with Pharmacists and Drug Pricing.

The MPDPF can be found on CMS' website at: www.medicare.gov/MPDPF/Home.asp. For the FY 2009 target, we are planning to add "patient safety" measures, and refine and refresh all report card measures.

For the enrollment performance measure, the baseline for CY 2006 was approximately 90 percent. This figure illustrates the initial success of the Medicare prescription drug program. CY 2007 trend data will be available February 2008, at which point the CY 2009 target will be set.

MCR12: Maintain CMS' Improved Rating on Financial Statements

Our annual goal is to maintain an unqualified opinion, which indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, budgetary resources, and financing of CMS. An independent audit firm reviews the financial operations, internal controls, and compliance with laws and regulations at CMS and its Medicare contractors.

CMS met its FY 2007 target of maintaining an unqualified opinion. During FY 2007, CMS continued to improve its financial management performance in many areas. Specifically, CMS was successful in addressing the FY 2006 Medicaid and Other Health Programs Oversight reportable condition (note that the term "reportable condition" has recently been changed to

"significant deficiency"). CMS also effectively transitioned three additional contractors to its Healthcare Integrated General Ledger System (HIGLAS) in FY 2007, bringing the total to ten Medicare contractors that have successfully transitioned. Since May 2005, CMS has processed more than 416.9 million claims and about $188.8 billion in payments through HIGLAS as of September 30, 2007. HIGLAS is now the system of record for these Medicare contractor sites.

During FY 2007, CMS continued to build upon its successful first year, FY 2006, of implementing OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control.* In addition, we provided a statement of reasonable assurance regarding the Agency's internal controls over financial reporting for June 30 and September 30.

MCR4: Decrease the Prevalence of Restraints in Nursing Homes

The purpose of this measure is to reduce the use of physical restraints in nursing homes. Since 1996 the prevalence of restraints has declined from a baseline of 17.2 percent. This measure was included in the FY 2006 Medicaid PART. In FY 2006, CMS exceeded its target of 6.4 percent with an actual of 6.1 percent. As a result of the reduction in restraints use from FY 2005 to FY 2006, about 7,000 fewer nursing home residents are physically restrained each day.

Nursing homes' recent success in reducing restraint use has accelerated due to the new and intense collaboration between survey and certification and the Quality Improvement Organizations, as well as careful work between CMS and nursing home in the new national campaign entitled *Advancing Excellence in Nursing Homes*. These efforts were more successful than anticipated in FY 2006, leading CMS to exceed its performance target.

CMS is working to improve surveyor training so that surveyors will be better able to detect inappropriate restraint use. CMS is also evaluating the inclusion of bedrails in the physical restraints measure. The FY 2008 target is set at 6.1 percent. While the FY 2006 result exceeds the FY 2007 target of 6.2 percent, CMS plans to examine future data to determine if the trend will continue before considering target revisions.

MCR5: Decrease the Prevalence of Pressure Ulcers in Nursing Homes

The purpose of this measure is to decrease the prevalence of pressure ulcers in nursing homes. CMS has met its targets since FY 2004, including FY 2006, where we exceeded our target of 8.8 percent with an actual prevalence of 8.2 percent. The Regional Offices have taken the lead in pressure ulcer reduction initiatives with activities that include monthly teleconferences to discuss problems and progress with this initiative.

While we are encouraged by recent downward trends, we are not yet certain that the trend will last. This prevalence of pressure ulcers is negatively affected if hospitals discharge patients to nursing homes in less stable conditions. Nonetheless, a decrease in the prevalence of pressure ulcers of 0.6 percentage points represents more than 8,000 fewer nursing home residents with a pressure ulcer. While FY 2006 results exceed future targets, we plan to examine future data to determine if the trend will continue before considering target revisions. Targets for FY 2008 and FY 2009 are both set at 8.5 percent. For FY 2008, CMS has elected to select States for Comparative Contractor Health Surveys based upon citation rates for pressure ulcer Federal Tag F314. Comparative health surveys are one type of Federal Monitoring Survey. About 50 of these surveys are carried out in nursing homes each year by a contractor. The primary purpose of these surveys is to gauge the effectiveness of the surveys that states conduct. Federal Tags are specific violations of the Code of Federal Regulations and are cited by nursing home

surveyors (inspectors) who conduct onsite inspections each year. Specifically, States with the lowest national rates of citation were selected for these surveys.

MCR1: Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive

Passage of the Medicare Modernization Act (MMA) prompted modifications in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) to include measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans as well as the Medicare Advantage (MA) and Medicare Fee-for-Service (FFS). In FY 2006, CMS developed the survey, and in FY 2007, CMS collected data on 2006 beneficiary experiences in the new plans. As a result, we developed four related measures to monitor beneficiary satisfaction with access to medical care and prescription drugs for both MA and FFS.

We met our FY 2007 target to set baselines and develop targets for FY 2008 and 2009. Our 2006 baselines are already high, and our future targets are to achieve 90 percent for MA and FFS access to care and 91 percent and 90 percent respectively for MA and FFS access to prescription drugs. Our strategies to continue achieving high rates include updating material for plans and providers on how to improve their CAHPS scores as well as doing some targeted work with plans to focus on quality improvement activities.

The current targets measuring Medicare plan enrollees who report they usually or always get needed care in a timely manner and have access to prescribed medications demonstrate a commitment by Medicare to assure high levels of care satisfaction in measures that are purposeful and meaningful. Medicare will analyze data at the plan, enrollee subgroup, and geographic levels to help plans develop interventions that are both actionable and targeted to maintain or improve measures.

MCR2: Improve Medicare's Administration of the Appeals Process

The appeals process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. Under fee-for-service (FFS) Medicare, beneficiaries and providers have the right to appeal a denial of payment by a Medicare fiscal intermediary or carrier. Under the Medicare Advantage program, these appeals may also involve pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

The Medicare Appeals System (MAS) is a workflow tracking and reporting system designed to support the end-to-end level two and level three appeals process. In the MAS, the Qualified Independent Contractors (QIC) for FFS, the Independent Review Entity for Medicare Advantage, the Part D QIC, and the level three Office of Medicare Hearings and Appeals process and adjudicate Medicare appeals in one system. To help improve the functionality of the MAS, CMS meets with the system developer/maintainer on a weekly basis to identify system enhancement needs. As a result, the MAS is better equipped to meet the informational needs of CMS and the QIC program. The MAS provides more reliable and consistent data with each upgrade, and allows management staff to make better decisions at all levels of the program.

CMS met the FY 2007 target when two major releases went into production on October 21, 2006 and December 16, 2006. The last major release for FY 2007 was successfully released into production on July 15, 2007.

The FY 2009 target is to enhance the MAS and support major MAS releases in order to bring the system more in-line with the user needs. CMS expects to continue enhancing the system over the next few years in order to simplify the appeals process and better serve the beneficiary and provider communities.

MCR9: Improve Beneficiary Telephone Customer Service

A CMS Quality Call Monitoring (QCM) process is used by the Beneficiary Contact Center to evaluate each Customer Service Representative's (CSR) performance in responding to Medicare beneficiary telephone inquiries. The Beneficiary Contact Center is responsible for evaluating and scoring each Customer Service Representative's performance in handling four telephone inquiries each month using the quality standards of privacy act, knowledge skills, and customer skills. As part of the QCM process, weekly calibration sessions are held in which all sites listen to and score a single call and compare results. These sessions ensure consistency and accuracy in scoring, thereby improving morale amongst CSRs and increasing productivity. Furthermore, they highlight areas for improvement across all areas of the call center and are regularly attended by training and content teams members to identify content and training improvements.

The Beneficiary Contact Center has exceeded the FY 2007 target of 90 percent for each standard by a minimum of four percentage points, and has also incorporated Virtual Call Center Strategy initiatives over the past fiscal year. Although the QCM targets have been exceeded over the past years, CMS has chosen to maintain targets at the same level in light of agency priorities.

In the future, the target setting methodology will remain the same. However, by FY 2009, the Beneficiary Contact Center performance, in meeting quality standards, will be assessed by an independent quality assurance contractor using a revised scorecard with new scoring logic. It is expected that these changes will impact the Beneficiary Contract Center scores/performance. The intent of this change is to move from a self-reporting environment and gather more detail on where improvements can be made in handling telephone inquiries to better serve the Medicare beneficiary population.

MCR11: Increase the Use of Electronic Commerce/Standards in Medicare

The objective of this performance measure is to maintain, and, in the long-run, increase the percentage of transactions accomplished electronically, rather than using paper format, telephone, or through another manual process. All FY 2007 electronic commerce targets were exceeded. Actions like monitoring Administrative Simplification Compliance Act enforcement, continuously enhancing free software for Electronic Remittance Advice, and eliminating duplicate remittance advice in paper format to providers and suppliers has contributed to us reaching and ultimately surpassing the targets. Continuous monitoring and taking quick and effective corrective actions have helped to raise confidence in electronic commerce among providers/suppliers. Because providers/suppliers can automate their systems to send claims, review and post payments, take follow-up actions faster, and avoid expensive errors, the overall success of this measure leads to reduced costs and increased efficiency for the provider/supplier community.

CMS is continuing the process of reducing paper and increasing usage of electronic transactions. Constant monitoring, identifying current and potential problems and taking timely corrective actions and increasing outreach activities are some of the steps being taken to improve program performance.

Based on a wide range of factors, the FY 2008 targets have been revised. Electronic Media Claims has been removed from this measure because we have reached a level that can be expected to be the maximum level for both intermediaries and carriers.

We are updating the Electronic Remittance Advice targets for FY 2008 from 55 percent and 37 percent to 59 percent and 45 percent for intermediaries and carriers, respectively, based on actual performance in FY 2007, as well as strategies that CMS has implemented and expects to implement to improve share of ERA in total remittance advice sent. The FY 2009 targets have similarly been revised from 59 percent and 45 percent, to 60 percent and 46 percent for intermediaries and carriers, respectively.

When the targets for FY 2006 and FY 2007 were developed, we expected that the challenges of the new MAC environment would adversely affect performance on this measure, which did not occur. This unexpected increase in electronic claims has resulted in more efficient and effective management of the program.

With the change in the Medicare enrollment application, which requires that providers submit the Electronic Funds Transfer Authorization Agreement (CMS-588) in conjunction with the submission of the Medicare enrollment application (CMS-855), we achieved our FY 2007 target of obtaining 100 percent Electronic Funds Transfer (EFT) for all new providers. Also, any existing provider that submits a CMS-855 change of information or re-validation application must at that time switch to EFT. Thus, the number of providers on EFT will continue to move upward. As a result of this progress, the EFT target will also be removed from this measure.

MCR14: Mature the Enterprise Architecture Program

The purpose of this measure is to ensure that Information Technology (IT) requirements are aligned with the business processes that support CMS' mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS' IT Systems. CMS has met its targets for the past four years. In FY 2007, CMS did the following to meet its target: applied Health and Human Services (HHS) naming convention standards and remapped CMS technologies to the HHS technology layer, developed a CMS Business Reference Model defining the CMS Lines of Business and enterprise services, took ownership of the HHS Health Care Administration segment, and graduated five Certified Enterprise Architects, which supports the CMS Strategic Five Alive Goal to have a "skilled, committed, and highly motivated workforce". In addition, critical partner reviews resulted in above average scores of 4's and 5's in the EA section of the OMB 300.

For FY 2008 and FY 2009, CMS will continue maturing the Enterprise Architecture by doing the following: establish management practices, process and policies to develop and oversee EA, expand the EA Repository and integrate EA with CMS' Capital Planning and Investment Control (CPIC) process. Changing priorities or directives could impact this goal. CMS' business community continues to benefit from the increased visibility into the Agency's processes. Maturing EA allows for realistic insight into the support networks, both technological and strategic, that provide the fundamental underpinnings to the work of the Agency.

MCR15: Strengthen and/or Maintain Diversity at all Levels of CMS

Workforce diversity has evolved from sound public policy to a strategic business imperative. A diverse workforce is good business practice yielding greater productivity and competitive advantage and is critical to CMS achieving its mission relative to employees, customers, suppliers and stakeholders.

CMS is committed to maintaining an effective affirmative employment program that is consistent with the requirements set forth in the U.S. Equal Employment Opportunity Commission's (EEOC) Management Directive (MD) 715 for all areas within the agency's purview that provide full employment opportunities for all employees and applicants for employment. When assessing "maintaining diversity at all levels," the agency monitors retention, career development, awards and recognition, and special emphasis programs and related activities as we strive to achieve the thresholds established by the National Civilian Labor Force (NCLF).

Through recruitment and retention efforts, CMS made progress in achieving its FY 2007 diversity goal by increasing representation in the Hispanic, African American, Asian, and two or more race demographic groups. Non-white EEO groups accounted for 35.4 percent of the CMS permanent workforce in FY 2007 compared to 34.7 percent in FY 2006. This exceeds the overall representation as reflected in the NCLF of 27.2 percent (based on 2000 Census statistics). Women comprised 66.78 percent of the total CMS permanent workforce in FY 2007, compared to a NCLF representation of 46.8 percent. Additionally, the FY 2007 participation rates of African American females, all American Indians, Asian American females, and White females in the CMS permanent workforce meet or exceed their 2000 NCLF cohort participation rates.

Hispanic, African American male, Asian male and White male representation at CMS is again below the NCLF with only a slight increase for Asian males. The agency continues to build upon its strategy to eliminate potential barriers and increase participation rates as is outlined in its FY 2007 MD-715 Report. CMS has been successful in maintaining a positive net change of Hispanic (6.77 percent) and Asian (4.88 percent) representation at year end. Additionally, the net change of hires compared to separations for men continue to improve (from -5.44 percent in FY 2006 to -1.32 percent in 2007).

Regarding employees with targeted disabilities, CMS has experienced a net change (hires vs. separations) in FY 2007 of -6.8 percent. This has resulted in a participation rate of 1.83 percent compared to 1.9 percent in FY 2006. CMS continues to have challenges in the recruitment, hiring, and retention of individuals with targeted disabilities in the CMS workforce. In FY 2007, the number of employees with targeted disabilities decreased from 88 to 82 (2.0 percent to 1.8 percent). The agency has developed a special multi-pronged program plan for the recruitment, hiring and advancement of individuals with targeted disabilities for FY 2008.

To improve retention rates, CMS has re-introduced its mentorship program to all permanent civilian and Commissioned Corps employees. This career development and enhancement program will optimize succession planning efforts, the transfer of institutional knowledge and leadership skills, and the retention of employees throughout the CMS and has active senior level support. Additionally, CMS has developed a Diversity Roadmap to effectively implement a strategy to recruit, hire and retain a highly-skilled and motivated workforce that reflects the national community and our diverse beneficiary population. To capture feedback from various groups, CMS conducted interviews with organizations to gain insight into effective outreach, recruitment and retention strategies.

MCR6: Percentage of States that Survey All Nursing Homes at Least Every 15 Months

Federal statute requires that every nursing home be surveyed at least every 15 months. States that do not complete all required surveys are assessed a penalty. The purpose of this measure is to measure CMS and survey partners' success in meeting core statutory obligations for carrying out surveys with routine frequency to assure quality of care to residents of our nation's

nursing homes. This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008.

Targets for FY 2008 and FY 2009 are 80 percent and 85 percent, respectively. The major internal factor affecting this measure is the requirement that CMS ensure proper operational controls, such as training and regulations, are in place. To meet these targets, CMS issues an annual Mission and Priority Document which states the agency's policies and the statutory survey frequency requirements. The Mission and Priority document also prioritizes the requirements for conducting recertification surveys for the non-statutorily mandated provider/supplier type to assure that the statutory survey timeframes are completed. CMS also conducts a formal assessment of whether the State survey agencies fulfill their outlined responsibilities. CMS uses a set of standards to determine whether the State survey agencies are meeting the requirements for the survey and certification program and to identify areas for improvement in management. For States that do not meet statutory requirements, CMS may make a non-delivery deduction from the State's subsequent funding, as described below under MCR8.

CMS and State survey agencies face significant challenges as we seek to ensure quality in the provision of Medicare and Medicaid services. One challenge is simply to sustain the improvements made in the survey system in recent years. Other examples include: increases in the number of providers requiring onsite surveys, new responsibilities (such as transplant surveys) and other uncertainties at both the federal and State levels. In light of these challenges, CMS has sought to promote the highest State survey performance as possible redirecting resources to increase program efficiency and effectiveness

MCR7: Percentage of States That Survey All Home Health Agencies at Least Every 36 Months

Federal statute requires that every home health agency be surveyed at least every 36 months. State agencies that do not complete all required surveys are assessed a penalty. The purpose of this measure is to measure CMS and its survey partners' success in meeting core statutory obligations for carrying out surveys with routine frequency to assure quality care to beneficiaries who receive care from the nation's home health agencies. This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008.

Targets for FY 2008 and FY 2009 are 70 percent and 75 percent, respectively. The major internal factor affecting this goal is the States' and Regions' ability to provide adequately trained personnel and follow proper survey protocols outlined in the regulations and State Operations Manual for the survey of Home Health Agencies. To meet these targets, CMS issues an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements. The Mission and Priority Document also prioritizes the requirements for conducting recertification surveys for the non-statutorily mandated provider/supplier type to assure that the statutory survey timeframes are completed. CMS also conducts a formal assessment of whether the State survey agencies fulfill their outlined responsibilities. CMS uses a set of standards to determine whether the State survey agencies are meeting the requirements for the survey and certification program and to identify areas for improvement in management. For States that do not meet statutory requirements, CMS may make a non-delivery deduction from the State's subsequent funding, as described below under MCR8.

CMS and State survey agencies face significant challenges as we seek to ensure quality in the provision of Medicare and Medicaid services. One challenge is simply to sustain the

improvements made in the survey system in recent years. Other examples include: increases in the number of providers requiring onsite surveys, new responsibilities (such as transplant surveys) and other uncertainties at both the federal and State levels. In light of these challenges, CMS has sought to promote the highest State survey performance as possible by redirecting resources to increase program efficiency and effectiveness.

MCR8: Percentage of States for Which CMS Makes a Non-Delivery Deduction from the States' Subsequent Year Survey and Certification Funds for Those States that Fail to Complete all Statutorily-Required Surveys

The purpose of this new measure is to assure that States accomplish surveys within the set timelines. States that do not comply are assessed a non-delivery deduction on the following fiscal year's allocation, which is equal to 75 percent of the estimated cost of the uncompleted nursing home or home health agency surveys. The deduction cannot exceed two percent of the State's survey and certification budget. In certain circumstances, despite systems that encourage full compliance with conducting statutorily-mandated surveys, imposition of a non-delivery deduction that would normally be assessed for non-delivery performance would only exacerbate future State performance. In any non-delivery deduction situation, we will carefully review the State's performance, discuss their plan for improvement, and determine whether the deduction would encourage compliance or serve only to worsen the situation. Therefore, we do not anticipate that we would impose deductions in 100 percent of applicable circumstances. This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008.

Targets for FY 2008 and FY 2009 are 70 and 75 percent, respectively. The major internal factor affecting this measure is the requirement that CMS ensure proper operational controls, such as training and regulations, are in place. To meet these targets, CMS issues an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements that States must meet. The Mission and Priority Document also prioritizes the requirements for conducting recertification surveys for the non-statutorily mandated provider/supplier type to assure that the statutory survey timeframes are completed. CMS also conducts a formal assessment of whether the State survey agencies fulfill their outlined responsibilities. CMS uses a set of standards to determine whether the State survey agencies are meeting the requirements for the survey and certification program and to identify areas for improvement in management.

CMS and State survey agencies face significant challenges as we seek to ensure quality in the provision of Medicare and Medicaid services. One challenge is simply to sustain the improvements made in the survey system in recent years. Other examples include: increases in the number of providers requiring onsite surveys, new responsibilities (such as transplant surveys) and other uncertainties at both the federal and State levels. In light of these challenges, CMS has sought to promote the highest State survey performance as possible by redirecting resources to increase efficiency and effectiveness.

Medicaid

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Outyear Target
				Target	Actual	Target	Actual			
Long-Term Objective: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs										
MCD1.1	Estimate the Payment Error Rate in the Medicaid Program	N/A	N/A	Begin to implement error measurement for Medicaid fee-for-service (FFS) in 17 States. Report a preliminary error rate in the FY 2007 PAR with the final error rate reported in the FY 2008 PAR.	Goal met.	Begin full implementation of measuring FFS, managed care and eligibility in the second set of 17 States for Medicaid. Report national error rate in FY 2008 PAR.	Nov-08	Report national error rates in the FY 2009 PAR based on 17 States measured in FY 2008	Report national error rates in FY 2010 PAR based on 17 States measured in FY 2009	Below Baseline (2012)
MCD1.2	Estimate the Payment Error Rate in SCHIP	N/A	N/A	N/A	N/A	Begin full implementation of measuring FFS, managed care and eligibility in 16 States (excludes Tennessee). Report national error rate in FY 2008 PAR.	Nov-08	Report national error rates in the FY 2009 PAR based on 17 SCHIP States measured in FY 2008	Report national SCHIP error rates in FY 2010 PAR based on 17 States measured in FY 2009	Below Baseline (2012)
Long-Term Objective: Increase the number of States that have the ability to assess improvements in access and quality of health care through implementation of the Medicaid Quality Strategy										
MCD2	Number of States participating in Medicaid Quality Improvement Program	N/A	N/A	N/A	N/A	Baseline (0 States)	Feb-08	15% of States (8 States)	18% of States (9 States)	26% of States (13 States) (2013)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
MCD 3	Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	N/A	N/A	N/A	43.6%	Base-line	Mar-08	45%	46%
MCD 4	Percentage of Beneficiaries who Receive Home and Community-Based Services	N/A	N/A	N/A	N/A	Base-line	Sep-09	+3% over FY 2007	+3% over FY 2008
MCD 5	Percentage of Section 1115 demonstration budget neutrality reviews completed	N/A	N/A	Base-line	100%	N/A	N/A	92%	96%
MCD 6	Medicaid Integrity Program, Percentage Return on Investment	N/A	N/A	N/A	N/A	N/A	N/A	>100%	>100%
Appropriated Amount ($ Millions)		**$182,754**	**$177,541**	**$215,472**		**$168,255**		**$206,886**	**$216,628**

MCD1: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Program

In FY 2007, we began full implementation of the Payment Error Rate Measurement (PERM) program in Medicaid and SCHIP. CMS reported a preliminary Medicaid fee-for-service error rate in the FY 2007 Performance and Accountability Report (PAR) with a final error rate to be reported in the FY 2008 PAR.

The PERM measurement for each program includes a fee-for-service, managed care, and eligibility component. For the SCHIP program, Tennessee did not begin enrollment and provide services until midway through the FY 2007 measurement period, so they will produce an annual rate the next time they are measured in FY 2010. The fully implemented national Medicaid and SCHIP program error rates will be reported in the FY 2008 PAR. Likewise, we expect the FY 2008 rates to be published in the FY 2009 PAR.

Each year, 17 States will participate in the Medicaid and SCHIP measurement. At the end of a three year period, each State will have been measured once and will rotate in that cycle in future years, e.g., the States selected in FY 2006 will be measured again in FY 2009. We expect the FY 2009 rates will be published in the FY 2010 PAR.

We are measuring improper payments in a subset of 17 States each year as a means to contain cost, reduce the burden on States, and make measurement manageable. In this way, States

can plan for the reviews and CMS has a reasonable chance to complete the measurement on time for PAR reporting. However, in view of the fact that the program is relatively new, there may be unforeseen challenges that could impact our ability to complete timely measurement for FY 2007 and beyond until the program matures.

MCD2: Increase the Number of States that Have the Ability to Assess Improvements in Access and Quality of Health Care through Implementation of the Medicaid Quality Strategy

The purpose of this new measure is to increase the number of States that have the ability to assess improvements in access and quality of health care through technical assistance and to develop a National Medicaid Quality Framework, a consensus document developed by CMS and the States. For FY 2007, the approved baseline is zero. CMS is on track to reach the FY 2008 target to impact eight States and nine States in FY 2009.

This measure is highly dependent upon maintaining a collaborative partnership with States and other key stakeholders as the activities are voluntary and resources are limited. CMS has developed the prototype for the Quality Assessment Packets that will assist States in assessing quality and access to care. The packet contains a comprehensive assessment of State activities across a variety of settings and delivery systems and was disseminated to the first State in January 2008. In addition, CMS formally launched the development of a National Medicaid Quality Improvement Framework during the fall 2007 National Association of State Medicaid Directors conference. The launch begins the process of developing a framework that will identify basic tenets of a comprehensive Quality Improvement program, including high level principles and action steps to move the nation toward improved quality outcomes and efficiencies in Medicaid and to achieve safe, effective, efficient, patient-centered, equitable and timely care.

Achieving our targets supports CMS' goal of improving care for all Medicaid beneficiaries through a reformed system of care based on value-based purchasing to improve quality and efficiency.

MCD3: Percentage of Beneficiaries in Medicaid Managed Care Organizations and Health Insuring Organizations (MCOs + HIOs)

One of CMS' priorities is to work with States to explore cost-effective health delivery systems that increase efficiency, management, and the delivery of care. To that end, this measure tracks the percentage of enrollment of Medicaid beneficiaries in managed care. This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008.

The enrollment counts in the Medicaid Managed Care Enrollment Report are point-in-time counts, as of June 30 of each year. This point-in-time measure corresponds to the managed care enrollment counts captured by the States, and best reflects the ongoing monthly managed care enrollment activity. Baseline data will be available March 2008. Our FY 2009 target is 46 percent.

The Medicaid managed care enrollment statistics are obtained by a survey, using an automated tool, the Medicaid Managed Care Data Collection System.

MCD4: Percentage of Beneficiaries who Received Home and Community-Based Services

There is a growing body of evidence that home and community-based services (HCBS) can be more cost-effective than institutional care, and may result in improved quality of care/quality of

life for certain individuals. For example, the Government Accountability Office found that the shift to home and community-based care has allowed some States to provide services to more people with the same dollars available. In addition, beneficiaries can experience more person-centered care and improved quality of life under HCBS compared with institutional services at the same level of care. This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008.

Most HCBS are provided under section 1915(c) waivers, which are required to limit aggregate HCBS costs to less than the average institutional service costs individuals would otherwise receive. The Deficit Reduction Act (DRA) of 2005 acknowledged and reinforced the value of HCBS as alternatives to institutional care. DRA section 6086 established new authority for States to offer HCBS through their traditional Medicaid State plan program. Section 6071, Money Follows the Person Rebalancing Demonstration (MFP), encourages states to relocate persons from institutions to community-based settings and provide appropriate, high quality HCBS.

CMS is facilitating State decisions to increase the number of beneficiaries receiving HCBS, instead of institutional care, through: A revised application process for section 1915(c) HCBS waivers, including a web-based application and published, consistent, review criteria; Education and technical assistance outreach to help states implement section 1915(i) HCBS; Enhanced funding and technical assistance under MFP to reinforce and increase State efforts to serve beneficiaries with quality HCBS rather than institutions; Technical assistance and education for states concerning other authorities for HCBS including section 1915(j) self-directed services, section 1115 waivers, and other demonstrations and grants. Baseline information will be available September 2009.

MCD5: Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed Out of Total Number of Operational Demonstrations for Which Targeted Budget Reviews are Scheduled

This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008. Under section 1115 of the Social Security Act, the HHS Secretary has the authority to grant waivers to allow States to test innovative reforms such as new health care delivery systems. The Administration maintains a policy that any State demonstration should be budget neutral, meaning the demonstration should not create new costs for the Federal government. CMS is responsible for reviewing State compliance with budget neutrality for Medicaid demonstrations. The number of demonstration administrative actions (renewals, amendments, etc.) processed during the year provides an opportunity to perform reviews on all targeted demonstrations.

In FY 2006, our baseline year, the results for targeted reviews was 100 percent. CMS is planning targeted reviews for the next three fiscal years to take advantage of reviews associated with demonstrations that States are applying to renew, and thus undergoing a budget neutrality review. The FY 2008 data will be available March 2009. The FY 2009 target is to ensure 94 percent of the demonstrations are operating within the agreed upon budget neutrality limits and will be available March 2010. While these targets are lower than the FY 2006 actual, they are aggressive in terms of the number of reviews that will occur in relation to demonstration activities (i.e., renewals, amendments, etc.) that are on schedule to occur.

MCD6: Medicaid Integrity Program, Percentage Return on Investment (ROI)

The purpose of this measure is to assure the implementation and success of the Medicaid Integrity Program (MIP). This measure was developed as a result of the Medicaid Program

Assessment Rating Tool (PART) discussions and is a new measure for FY 2008. Once the program is established, resources committed, and the Medicaid Integrity Contractors procured and in operation, the targets for FY 2008 and FY 2009 are for the ROI to be greater than 100 percent. To calculate the ROI, the numerator will include annual total Federal dollars identified overpayments in accordance with the relevant Medicaid overpayment statutory and regulatory provisions. The denominator will include the annual Federal funding of the Medicaid Integrity Contractors. The DRA increased CMS' obligations and resources to help prevent, detect and reduce fraud, waste, and abuse in Medicaid. In addition to hiring 100 new full-time employees, Congress mandated that CMS enter into contractual agreements with eligible entities to conduct provider oversight by reviewing provider claims to determine if fraud and abuse has occurred or has the potential to occur, conducting provider audits based on these reviews and other trend analysis, identifying overpayments and conducting provider education.

State Children's Health Insurance Program

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out year Target
Long-Term Objective: Improve Health Care Quality Across the State Children's Health Insurance Program										
SCHIP2	Improve Health Care Quality Across SCHIP	Goal met. Refine data; produce standard format; collect baseline.	Goal met. Collect core data; use SARTS; Assist States.	25% of States reporting on 4 core performance measures.	Goal met.	Revise Template to reflect State improvement efforts.	Goal met.	Disseminate best practices.	Work with low performers. A "low performer" is any State that doesn't provide quantifiable and measurable performance measures in their FY 2006 SCHIP annual report.	N/A
Long-Term Objective: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP.										
SCHIP3	Decrease the number of uninsured children by working with States to enroll children in SCHIP.	N/A	N/A	N/A	Baseline: 6,600,000 children	N/A	N/A	Increase FY 2006 enrollment by 2%	Increase FY 2006 enrollment by 3%.	Increase FY 2006 enrollment by 12%. (2012)
Long-Term Objective: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs										
MCD1.2	Estimate the Payment Error Rate in SCHIP	N/A	N/A	N/A	N/A	Begin full implementation of measuring FFS, managed care and eligibility in 16 States for SCHIP (excludes Tennessee) Report national error rate in FY 2008 PAR.	Nov-08	Report national SCHIP error rates in the FY 2009 PAR based on 17 States measured in FY 2008	Report national SCHIP error rates in FY 2010 PAR based on 17 States measured in FY 2009	Below Baseline (2012)
Appropriate Amount ($ Millions)		**$3,175.2**	**$4,082.4**	**$4,082.4**		**$5,040.0**		**$6,640.0**	**$5,315.0**	

SCHIP2: Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program

The purpose of this measure is to improve health care quality across Medicaid and SCHIP. Since its inception, States have shown dramatic improvement in reporting SCHIP performance measures. CMS met the FY 2007 target to revise the FY 2006 annual report template. The

template was revised to better capture States' quality improvement activities, to identify promising practices, and to determine if the States are taking action based on the analysis of quality data.

CMS doubled its efforts to provide targeted technical assistance to States regarding the development and reporting of performance measures, including quality improvement efforts. States programmatic changes, reporting accuracy, and timeliness and Federal SCHIP reauthorization programmatic changes are factors that could impact this measure. The FY 2008 and FY 2009 targets reflect the next steps: dissemination of States' quality improvement strategies and assisting States with lower performance rates by providing technical assistance based on best practices to facilitate quality improvement. CMS identifies a “low performer” as any State that doesn’t provide quantifiable and measurable performance measures in their FY 2006 SCHIP annual report. Additionally, CMS has provided States with a reporting “checklist” on performance measures and has included SCHIP performance quality improvement information in Medicaid Quality Assistance packets provided to States. (see MCD2).

SCHIP3: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP

The purpose of this measure is to decrease the number of uninsured children by working with the States to enroll targeted low-income children in SCHIP. A previous goal measured combined enrollment in SCHIP and Medicaid. SCHIP enrollment increased 8.2 percent between FY 2005 and FY 2006, while Medicaid enrollment decreased 2.6 percent during the same period. A combined measurement shows an overall enrollment decrease of 0.8 percent between FY 2005 and FY 2006. To accommodate unrelated fluctuations in Medicaid data in the future, the new measure will only address increases in SCHIP enrollment.

The FY 2009 target is to increase enrollment of targeted low-income children in SCHIP by three percent over the 2006 baseline of 6,600,000 children. States submit quarterly and annual SCHIP statistical forms, which report the number of children under age 19, who are enrolled in separate SCHIP programs and Medicaid expansion SCHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year. The ever enrolled measure accurately represents the program’s enrollment each year and we will continue using this as our measure. Many factors will affect SCHIP enrollment, including States' economic situations, programmatic changes, and enrollment reporting accuracy and timeliness. The FY 2009 Budget proposes to reauthorize SCHIP through FY 2013 and increase allotments by $19.7 billion over that period to meet anticipated State need in covering low-income children.

Medicare Integrity Program (HCFAC)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
Long-Term Objective: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program										
MIP 1	Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program	10.1%	5.2%	5.1%	4.4%	4.3%	3.9%	3.8%	3.7%	TBD (FY 2010)
Long-Term Objective: Reduce the Medicare Contractor Error Rates										
MIP 4	Percentage of Contractors with an error rate less than or equal to the previous years national paid claims error rate	Set Baseline	89.6%	50%	82.8%	75%	78.7%	85%	90%	95% (FY 2010)
Long-Term Objective: Improve the Provider Enrollment Process										
MIP 2.1	Develop and Implement Provider Enrollment, Chain and Ownership System (PECOS)-Web	Develop web-enabled enroll-ment process via PECOS for both Part A and Part B	Re-design provider enroll-ment applica-tions; continue web-enabled enroll-ment process; Establish an accep-table level of pending enroll-ment actions and maintain the level of inventory	Publish revised enroll-ment applica-tions for all provider and supplier types and continue making enhance-ments to PECOS	Goal met	Continue making en-hance-ments to PECOS	Goal met	Implement PECOS-Web for all providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers continue making enhance-ments to PECOS	Implement PECOS-Web for DMEPOS suppliers and continue making enhance-ments to PECOS	N/A

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target	Out-year Target
				Target	Actual	Target	Actual			
MIP 2.2	Maintain fee-for-service processing timeliness standards	N/A	N/A	N/A	N/A	Maintain fee-for-service processing timeliness standards	Goal not met	Maintain fee-for-service processing timeliness standards	Maintain fee-for-service processing timeliness standards	N/A
MIP 2.3	Implement a Provider Enrollment Appeals Process	N/A	N/A	Consistent with section 936 of MMA, develop a provider enrollment appeals process	Goal met	Publish a proposed rule regarding the provider enrollment appeals process	Proposed rule published on March 2, 2007	Publish a final rule that implements a provider enrollment appeals process.	N/A	N/A
MIP 2.4	Publish a Medicare Enrollment Regulation	N/A	Publish final enrollment regulation	Publish final Medicare enrollment regulation	Regulation published April 21, 2006	N/A	N/A	N/A	N/A	N/A
Long-Term Objective: Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers										
MIP 3	Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers	Goal met 18 additional VDSAs.	Goal met 26 additional VDSAs.	Sign 8 additional VDSAs	Goal met 23 additional VDSAs.	Sign 8 additional VDSAs	Goal met 11 additional VDSAs.	Sign 8 additional VDSAs	Sign 8 additional VDSAs	N/A
Appropriated Amount ($ Millions)		**$720**	**$720**	**$832**		**$744**		**$756**	**$768**	

MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program

The purpose of this measure is to continue to reduce the percentage of improper payments made under the fee-for-service program as reported in the CMS Financial Report. One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible

beneficiaries. Paying correctly the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. Given the size of Medicare expenditures, even small payment errors represent an impact to Federal treasuries and taxpayers. CMS uses improper payment information as a tool to preserve the fiscal integrity of the Medicare program and achieve the HHS Strategic Plan objective to improve the value of health care.

The complexity of Medicare payment systems and policies, as well as the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. CMS has implemented an Error Rate Reduction Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate. This plan, which is updated annually, includes strategies to clarify CMS policies and target provider education and claim review efforts to services with the highest improper payments.

The Comprehensive Error Rate Testing (CERT) program was initiated in FY 2003 and has produced a national error rate for each year since its inception. Before FY 2003, OIG produced error rate information. In 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. This change was necessary in order to comply with new Improper Payments Information Act (IPIA) requirements.

The paid claims error rate was 14 percent in 1996 and decreased to 10.1 percent in FY 2004. CMS' error rate reduction activities have resulted in significant reductions in the error rate over the past four years. The FY 2007 paid claims error rate was 3.9 percent, exceeding the 4.3 percent target by 0.4 percentage points. CMS activities were more effective than expected in reducing the error rate. In light of this unexpected result, targets for FY 2008 and FY 2009 have been adjusted to continue to pursue aggressive reductions in the FFS error rate. Most of the reduction in FY 2007 rate was a result of decreasing the number of insufficient documentation errors. Over the past couple years the CERT program has focused on reducing no documentation and insufficient documentation errors by making more intensive efforts to locate and contact providers to request missing documentation. Additional reductions occurred in medically unnecessary and incorrect coding errors. CMS will continue to use the CERT program to hold the FFS contractors accountable for the services they provide as CMS moves from contracts that simply pay contractors to process Medicare claims to performance-based contracts. More information about the error rate findings, and the actions CMS is taking to reduce errors, is published bi-annually in the report of Improper Medicare FFS Payments available at www.cms.hhs.gov/cert.

Since the error rate has already been substantially reduced, more targeted strategies will be needed to obtain further reductions. CMS is pursuing strategies directed at specific regions, providers, and error types, including developing new data analysis procedures to identify payment aberrancies and using that information to preemptively stop improper payments and directing Medicare contractors to develop local efforts to lower the error rate by developing plans that address the problems that result in errors.

MIP4: Reduce the Medicare Contractor Error Rates

The Comprehensive Error Rate Testing (CERT) program produces the Medicare national fee-for-service error rate. The CERT program provides overall detail and analysis of program vulnerabilities. For each Medicare contractor, CERT conducts reviews for a statistically valid sample of claims to determine if the contractor made the correct payment determination. The

results reflect not only the contractor's performance, but also the billing practices of the health care providers in their region.

The FY 2007 target for claims processed by contractors with error rates less than or equal to the previous years national paid claims error rate was exceeded by 3.7 percentage points. The target was exceeded because of the reduction in contractor specific error rates. Over the past year each CERT participating Medicare contractor has worked on educational and procedural elements to help reduce the error rate in their jurisdiction. Refinements in the CERT process have played a minor role in reducing contractor specific error rates. Improvements in the documentation submission process have helped contractors avoid no-documentation and insufficient documentation errors.

The CERT program reports estimated contractor specific error rates. Based on the contractor specific information, CMS requires contractors to develop targeted error rate reduction plans to reduce payment errors. The error rate reduction plan reports a contractor's actions in provider education, medical review, and other error reduction activities. CMS also uses the contractor specific error rate information in contractor's annual performance evaluation.

CMS expects that operational changes occurring in the Medicare program will impact the improper payment rate in upcoming years. These changes include the transition of Medicare FFS contracts from carriers and fiscal intermediaries to Medicare Administrative Contractors and the consolidation of the HPMP and CERT programs.

This measure encourages CMS and the Medicare contractors to continually strive to reduce errors at the contractor level. By FY 2009, CMS intends to have 90 percent of Medicare claims processed by contractors that have an error rate less than or equal to the previous year's actual national paid claims error rate. Critically important in reducing the contractor error rate is determining the root causes of error. Once the cause is determined, CMS can take action to review systems, clarify policy, or modify CMS technical requirements.

MIP2: Improve the Provider Enrollment Process

CMS will use the Provider Enrollment, Chain and Ownership System (PECOS) to capture Medicare enrollment information on all Medicare fee-for-service providers and suppliers, except durable medical equipment suppliers. The PECOS database maintains enrollment information on Part A providers that bill fiscal intermediaries and Part B providers, including individual practitioners that bill carriers. Medicare fee-for-service contractors use PECOS to enroll new providers and suppliers into the Medicare program, update provider and supplier enrollment information, and process requests from individual health care practitioners for assignment of benefits.

In FY 2007, we published a proposed regulation to establish a provider enrollment appeals process, continued our efforts to develop and implement PECOS-Web for all providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. In some cases, our contractors did not meet or maintain the CMS process enrollment processing timeliness standards. CMS conducted on site visits to those contractors who were not meeting performance expectations and made recommendations to improve processing timeliness and accuracy. In addition, CMS meets regularly with contractors to discuss processing concerns. With the implementation of PECOS-Web in FY 2008, we believe that contractors will be able to meet or exceed established processing standards.

In FY 2008, we expect to implement PECOS-Web for all providers and suppliers, except DMEPOS suppliers, finalize the provider enrollment appeals process through regulation, and maintain processing timeliness standards.

In FY 2009, we expect to implement PECOS-Web for DMEPOS suppliers, continue making enhancements to PECOS and maintain fee-for-service processing timeliness standards.

MIP3: Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers

The purpose of this measure is to increase the number of Voluntary Data Sharing Agreements (VDSAs) that CMS has with large employers and insurers for the purpose of exchanging employer or insurer health plan enrollment information for Medicare eligibility information. The VDSA allows CMS to receive this health plan coverage information from employers or insurers on a current (quarterly) basis, which enables Medicare to correctly process Medicare claims for primary or secondary payment.

CMS has made great strides to sign VDSAs with large employers/insurers and has included the expansion of this initiative as part of CMS' goal to reduce the incidences of mistaken payments under the FY 2007 MSP comprehensive plan. We met our FY 2007 goal by signing 11 additional VDSAs.

In recognizing that the existing VDSA process could be leveraged to implement portions of the Medicare Modernization Act, CMS expanded both the size and scope of the VDSA process to meet the new coordination requirements related to the administration of the Medicare Part D drug benefit. This expansion makes the VDSA even more beneficial to our employer and insurer partners, and we expect the number of new agreements to grow over the next few years. Also, in identifying the fact that the new drug benefit will require CMS to coordinate benefits with entities that CMS has not had a need to coordinate benefits with in the past, CMS developed a new VDSA process to exchange MSP drug coverage information with pharmacy benefit management companies. The FY 2009 target is to sign 8 additional VDSAs.

State Grants and Demonstrations

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective: Accountability through Reporting in the Medicaid Infrastructure Grant Program									
SGD 1	Prepare an annual report by December 31 for the preceding calendar year on the status of grantees in terms of States' outcomes in providing employment supports for people with disabilities.	N/A	N/A	Annual Report	Goal met	Annual Report	Goal met	Annual Report	Annual Report
Appropriated amount ($Millions)		**$142.0**	**$535.5**	**$2,565.5**		**$698.0**		**$764.0**	**$527.4**

SGD1: Accountability through Reporting in the Medicaid Infrastructure Grant Program

A key performance measure in the State Grants and Demonstrations Program relates to the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. The annual target for this measure is to prepare an annual report (new in 2006 covering calendar year 2005) on TWWIIA.

To meet our FY 2007 target, the second of these annual reports was prepared, summarizing the progress of Medicaid Infrastructure Grant (MIG) States during calendar year 2006. This report focuses primarily on quantitative data currently available for all States with MIG funding, using selected measures that are expected to be reported reliably and consistently over time. As more information is collected, future reports will provide a more complete picture of the types of activities supported by MIG funding, and the effect this funding has on people with disabilities who want to work.

In its next annual report on the MIG program, CMS will highlight continuing achievements in these existing measures, and will build on this report using any additional data collected from States. Though the data now measure many aspects of MIG performance, as more information is collected, future reports will provide a more complete picture of the types of activities supported by MIG funding and the effect this funding has on people with disabilities who want to work. CMS will use these reports to set conditions for future grants to the States, and believes that one of the strongest management tools it can employ is providing feedback to the grantees on their performance.

Clinical Laboratory Improvement Amendments

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long Term Objective: Improve Cytology Laboratory Testing									
CLIA1	Percent of pathologists receiving a passing score in gynecologic cytology proficiency testing	N/A	88% (CY 2005)	N/A	N/A	Promulgate appropriate regulatory changes to address issues based on formal recommendations from the Secretary of HHS' Clinical Laboratory Improvement Advisory Committee and analysis of 2005 and 2006 data.	Goal partially met.	93%	93%
Appropriated amount ($Millions)		**$43**	**$43**	**$43**		**$43**		**$43**	**$43**

CLIA1: Improve Cytology Laboratory Testing

There is a direct relationship between a cytology test finding and the diagnosis of a specific clinical disease. Gynecologic cytology testing provides the first indication of cervical cancer.

As of January 1, 2006, all laboratories that perform gynecologic cytology testing were enrolled in cytology proficiency testing (PT). CMS collected cytology PT data in CY 2006 to determine the percent performance rate of pathologists. As of January 1, 2006, 6280 pathologists were tested in gynecologic cytology PT. Eighty-eight percent (5554) of all pathologists tested received a passing score of 90 percent or greater.

As a result of CMS' educational approach and intervention, CMS is confident that 93 percent of all pathologists will, over time, achieve a passing score. Therefore, the FY 2008 target is for 93 percent of all pathologists to achieve a passing score, which is a 5 percent increase over the baseline data. CMS anticipates that pathologists will need additional time to become acclimated with the CMS cytology PT enrollment process, as well as become familiar with the testing process. We expect 93 percent of all pathologists to obtain a passing score in FY 2009. Laboratory professional organizations provide continuing education as well as mock tests to help pathologists become familiar with the cytology proficiency testing. However, enrollment in these programs is optional for laboratories.

The FY 2007 target was partially met. There is high Congressional interest in this topic and while CMS supports the continuation of cytology proficiency testing, pathologists continue to lobby for its elimination. Legislation has been introduced which resulted in Congressional briefings.

CMS' continued commitment to improving cytology laboratory testing helps to improve one of the principle issues on women's health, that is, accurate and reliable gynecologic cytology test results.

Quality Improvement Organizations (QIO)

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006		FY 2007		FY 2008 Target	FY 2009 Target
				Target	Actual	Target	Actual		
Long-Term Objective: Protect the Health of Medicare Beneficiaries									
QIO 1.1	Increase nursing home sub-population flu Immunization	Trend 73.0%	Trend 73.7%	74%	78.4%	74%	Dec-08	79%	79%
QIO 1.2	Increase national pneumococcal Immunization	67.4% (Goal met)	68.4%	69%	69.6%	69%	Dec-08	71%	71%
QIO 4	Increase percentage of timely antibiotic administration	68.2%	77.5%	75.4%	83.1%	82.0%	Jun-08	85.0%	87.0%
QIO 5	Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	36.4%	40.2%	40%	44.0%	47%	48%	51%	55%
Long-Term Objective: Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older									
QIO 2	Increase biennial mammography rates in women age 65 years and older	51.3%	52.1%	52.5%	52.7% (Goal met)	52.5%	Aug-08	53.0%	53.0%
Long-Term Objective: Improve the Care of Diabetic Beneficiaries									
QIO 3.1	Increase hemoglobin A1c testing rate	N/A	Trend 84.3%	N/A	Trend 85.2%	85.0%	Sep-08	85.5%	86%
QIO 3.2	Increase cholesterol (LDL) testing rate	N/A	Trend 78.1%	N/A	79.5%	80.0%	Sep-08	80.0%	80.5%
Appropriated Amount ($Millions)		**$251.3**	**$258.7**	**$258.1**		**$329.5**		**$344.2**	**$333.1**

QIO1: Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Through collaboration among the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC) and the National Foundation for Infectious Diseases/ National Coalition for Adult Immunization (NFID/NCAI), efforts are ongoing to improve adult immunization rates in the Medicare population.

We exceeded our 2006 nursing home influenza immunization target, and achieved our national pneumococcal immunization target. The September 2006 requirement for Minimum Data Set (MDS) immunization assessments of nursing home residents and publication of facility-specific

nursing home immunization rates on Nursing Home Compare undoubtedly contributed to the increase in both immunization rates. In addition, there were no influenza vaccine supply or distribution issues during the 2006-2007 influenza immunization season when in earlier years there were vaccine shortages and distribution delays.

As a result of the recent positive performance, we increased our influenza immunization target for FY 2008 from 74 percent to 79 percent and continued that target for FY 2009. We expect that the focus on attaining the goal in the long-term care population, an emphasis on preventive services, and recent changes to the immunization reimbursement methodology will result in dramatically increased immunization rates. CMS will continue to explore additional opportunities to improve adult influenza and pneumococcal immunization rates. Better immunization coverage of the nursing home population will, hopefully, contribute to increased overall immunization rates among people with Medicare.

QIO4: Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection

Postoperative surgical site infection (SSI) is a major cause of patient morbidity, mortality, and health care cost. SSI complicates an estimated 780,000 of nearly 30 million operations in the United States each year. For certain types of operations, rates of infection are reported as high as 20 percent. Each infection is estimated to increase a hospital stay by an average of 7 days and add an average of over $3,000 in hospital costs (1992 and 2005 data). The incidence of infection increases intensive care unit admission by 60 percent, the risk of hospital readmission five-fold, and doubles the risk of death. Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection. The reduction in the incidence of surgical site infection that is expected to result from improvement in the timing of antibiotic prophylaxis will primarily benefit Medicare beneficiaries through reduced morbidity and mortality. An additional benefit will be reduced need for and cost of rehospitalization for treatment of infections.

The goal of administering the antibiotic before surgery is to establish an effective level of the antibiotic in the body to prevent the establishment of infection during the time that the surgical incision is open. In 2001, CMS developed the national Medicare Surgical Infection Prevention (SIP) Project, which measured the frequency of antibiotic administration within the hour prior to five common types of major surgery (cardiac, vascular, hip/knee, colon, hysterectomy) where infection is most likely to be prevented with timely antibiotics. SIP evolved into the Surgical Care Improvement Partnership (SCIP) www.medqic.org/scip, which is a multifaceted coalition with the goal of reducing surgical complications, including SSI.

Several factors likely explain the better than expected results exceeding our FY 2006 target of 75.4 percent at a rate of 83.1 percent by 7.7 percentage points. Perhaps most importantly, the measure is strongly evidence-based and there have been few controversies about implementation. QIOs in most States sponsored collaborative learning sessions that targeted this and other SCIP measures during the 8th Scope of Work, and the Institute for Healthcare Improvement (IHI) included quality improvement interventions related to surgical antimicrobial prophylaxis in the Million Lives campaign. The number of hospitals capturing and reporting this measure to the QIO Clinical Warehouse increased from 1,718 to 3,247 in January 2006 (and subsequently up to 3,670 in July of 2006) based on inclusion of the SCIP antibiotic measures in the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Finally, the National SCIP Steering Committee supported broad scale participation in the SCIP by promotion and recruitment of member organizations and through many different organizational

newsletters and communications. Overall, these efforts were more successful than expected which led performance on this measure to exceed targets.

Internal factors affecting performance include prioritizing SCIP improvement activities in the QIO 8th Scope of Work and inclusion of the SCIP Infection measures as a part of the RHQDAPU program beginning in 2006. External factors affecting performance include the influence of the SCIP Steering Committee promotion of the project and the inclusion of surgical antimicrobial prophylaxis as a part of the IHI Million Lives Campaign. There were a few isolated pay-for-performance initiatives in the private sector that included the surgical antibiotic measures in the calculation of payment incentives.

Calculation of the impact on timely delivery of antibiotics on patient morbidity and mortality is challenging because antibiotic prophylaxis is but one of many processes of care that impact surgical site infection rates. In previous work done in the QIO program, hospitals that implemented a package of interventions designed to reduce surgical site infections (including timely delivery of antibiotics) demonstrated a 27 percent relative reduction in the rate of surgical site infections (from 2.3 percent to 1.7 percent). (Reference: Dellinger EP, Hausmann SM, Bratzler DW, Johnson RM, Daniel DM, Bunt KM, Baumgardner GA, Sugarman JR. Hospitals collaborate to decrease surgical site infections. *Am J Surg*. 2005;190:9-15.)

To achieve our FY 2008 and 2009 targets, we will continue emphasis of the performance measures of SCIP in the QIO 8th and upcoming 9th Scopes of Work and use the performance measures for continued accountability through public reporting and eventual value-based purchasing.

QIO5: Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis

Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD). Approximately 316,355 Medicare beneficiaries currently receive this treatment. Hemodialysis is a process of cleaning the blood of waste products when the kidneys can no longer perform this function. It requires removing the blood from the body, cleaning it, and returning it by means of a vascular access. Vascular access is one of the most critical issues in improving dialysis quality.

The three current types of vascular access are: fistula, catheter, and graft. Of the vascular access options, a fistula is generally the best access. An increased rate of fistulas for access would improve quality of life for patients by improving adequacy of dialysis and decreasing emergent treatment of complications and failures of grafts and catheters. Additionally, it is anticipated that the ESRD survival rate would improve because the complications of grafts and catheters can be fatal. Increasing the number of patients with fistulas as their access for dialysis would also decrease program costs associated with alternative forms of access such as graft revisions and care for infections, as well as emergency room usage and hospital stays for treatment of infections and failed catheters and grafts. About 25 to 50 percent of all hemodialysis patient admissions and hospital days are attributable to vascular access placement and related complications, which contributes over $1 billion to total Medicare inpatient costs.

CMS' FY 2007 target was to have 47.0 percent of prevalent hemodialysis patients use an arterio venous fistula (AVF) as their primary method of vascular access. As of the end of the fiscal year, of the 313,563 patients who obtain hemodialysis through CMS' ESRD benefit, 48.0 percent (150,473) had an AVF as their primary method of vascular access. Therefore,

CMS exceeded its target by a full percentage point, which translates to nearly 3,100 additional ESRD beneficiaries receiving AVFs than anticipated.

CMS met its FY 2007 target by reaching out to hemodialysis patients regarding the most appropriate vascular access methods available to them. CMS is holding ESRD Network Organizations accountable for driving regionally based fistula rates upward as one of their tasks under their CMS ESRD Quality Initiative Statements of Work. In addition, the work of the Fistula First National Coalition has continued to serve as a national coordinating point for pooling the resources of public and private stakeholders together to focus the renal community on this vital topic for all hemodialysis patients.

Patients utilizing an AVF for their hemodialysis treatments have fewer complications such as infections, interventional procedures for poorly working accesses, and hospitalizations. Research has also been conducted on the cost savings of AVF versus other methods of vascular access. In 2005, analysis by the US Renal Data System (USRDS) estimated that fistula patients incur lower healthcare costs than other hemodialysis patients. A fistula patient utilizes $58,294 per year, while a graft patient utilizes $67,479, and a catheter patient utilizes $74,963. Therefore, as a result of increasing AVF prevalence, CMS has taken great strides in improving the quality and safety of dialysis-related services provided for individuals with ESRD, as well as reducing the long-term resources required to maintain the health of these individuals.

To meet our FY 2008 and 2009 targets, CMS will continue to hold its ESRD Network Organization contractors accountable for decreasing the quality deficits in their served areas by increasing the number of prevalent hemodialysis patients using AVFs in their facilities. CMS will continue to monitor statistics of AVF prevalence on a regional and national level on a monthly basis, using its existing ESRD data collection and analysis tools.

QIO2: Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram

CMS is committed to improving early detection of breast cancer through increasing the rate of mammography in women 65 years and older. Women over 65 face a greater risk of developing breast cancer than younger women, and a disproportionate number of breast cancer deaths occur among older African-American women. Encouraging breast cancer screening, including regular mammograms, is critical to reducing breast cancer deaths for those populations.

We achieved our FY 2006 mammography target of 52.5 percent at a rate of 52.7 percent, exceeding our target by 0.2 percent, and as a result, revised our FY 2008 and 2009 targets from 52.5 percent to 53 percent. The target was exceeded due to continued local community efforts to promote screening mammography, combined with national awareness efforts by CMS and distribution of educational materials created by CMS, the National Cancer Institute, and the Centers for Disease Control & Prevention. This effort is also reflected in the QIO 9th Scope of Work, which is due to begin August 1, 2008.

Comparing the FY 2006 result (52.7 percent) with FY 2005 (52.1 percent) means that approximately 82,518 more women with Medicare age 65 and over had a mammogram during 2005-06, compared with 2004-05.

CMS faces several challenges to achieving targets for this goal or for pursuing more aggressive targets. One factor is the publication of occasional articles in the press (both general and medical/scientific) since 2001-2002 questioning the benefits of screening mammography. Attempts to reaffirm the recommendations for regular mammography screening by

governmental agencies and national associations received less media attention. Additionally, a recent study suggests that the required copayment may be a deterrent to beneficiaries obtaining mammograms.

QIO3: Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol (LDL) Testing

CMS is committed to improving care for its diabetic beneficiaries by increasing the rate of hemoglobin A1c and cholesterol (LDL) testing. Multiple studies have demonstrated a relationship between good control of blood sugars as measured by hemoglobin A1c levels and protection against the development and/or progression of the devastating complications of diabetes. Cardiovascular complications of diabetes are common and cause heart attacks, strokes and lower extremity amputations. In fact, cardiovascular disease is the number one cause of death for patients with diabetes. High levels of cholesterol, especially the LDL lipid fraction, as well as poor control of blood sugars are both associated with diabetes-related cardiovascular disease. Testing hemoglobin A1c and lipid levels and treating cholesterol and glucose levels to target levels have both been shown to significantly decrease the cardiovascular complications of diabetes.

We met our FY 2006 target to set baselines and targets for FY 2007-FY 2009. FY 2007 data will be available September 2008. As a result of more recent interim trend data and the fact that the QIO 9th Scope of Work will focus on increasing testing rates in minority populations in 33 States, we are adjusting our FY 2008 and 2009 cholesterol testing targets slightly to 80 percent and 80.5 percent, respectively, to reflect these factors and provide a balance of continuing to pursue improvement in quality while setting a realistic, achievable target.

Target vs. Actual Performance
Performance Measures with Slight Differences

"The performance target for the following measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance."	
Program	**Measure Unique Identifier**
Medicare	MCR3.1a
Medicare	MCR3.1b
Medicare	MCR4
Medicare	MCR5
Medicare	MCR10.1
Medicare	MCR10.2
Medicare	MCR11.1
Medicare	MCR11.2
Medicare	MCR11.4
Medicare	MCR13.2
Quality Improvement Organizations	QIO1.2
State Children's Health Insurance Program	SCHIP1
Medicare Integrity Program	MIP3
Medicare Integrity Program	MIP4

Strategic Plan Discussion

Consistent with the principles of the Government Performance and Results Act (GPRA), CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. CMS' FY 2009 performance budget reinforces CMS, HHS and Administration priorities including the HHS Strategic Plan and CMS strategic goals. For a link of the HHS and CMS strategic goals, please see the chart below.

CMS' strategic goals and objectives are developed in conjunction with the HHS Strategic Plan, and outline specific goals for achieving our mission. CMS' strategic goals, the HHS strategic plan, the enactment of GPRA, the HHS management plan, the President's Management Agenda, the Secretary's Priorities and other HHS and government-wide programs have all emphasized the themes of accountability, stewardship and a renewed focus on the beneficiary.

There is a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. We will communicate, collaborate, and cooperate with key customers, both public and private, to help us achieve the desired outcomes stated in this performance budget.

The important work performed by CMS as outlined in our Strategic Action Plan helps support HHS strategic objectives. 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. This reinforces HHS Strategic Goals 1 and 2.

To improve the safety, quality, affordability and accessibility of health care, CMS is developing and executing effective oversight and aggressive provider education and outreach, achieving strong financial performance for its programs and operations. Oversight will include expanded modernized program integrity for Medicare and Medicaid and preventing improper payments. This reinforces HHS Strategic Goal 1.

To promote public health promotion and protection, 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. These efforts reinforce HHS Strategic Goals 1, 2, 3 and 4.

CMS helps to promote the economic and social well-being of individuals, families and communities by developing 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. This reinforces HHS Strategic Goals 1, 2 and 3.

CMS recognizes that its success is dependent on collaborative relationships with a variety of organizations, individuals, and institutions to improve the safety, quality, affordability and accessibility of health care, promote the economic and social well-being of individuals, families, communities as well as economic independence and social well-being. This reinforces HHS Strategic Goals 1, 2 and 3.

	CMS Strategic Action Plan Objectives				
	Skilled, Committed and Highly-Motivated Workforce	Accurate and Predictable Payments	High Value Health Care	Confident, Informed Consumers	Collaborative Partnerships
HHS Strategic Goals & Objectives					
Strategic Goal 1 Health Care - Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care					
Strategic Objective 1.1 – Broaden health insurance and long-term care coverage			X	X	X
Strategic Objective 1.2 – Increase health care service availability and accessibility		X	X	X	X
Strategic Objective 1.3 – Improve health care quality, safety, cost and value		X	X	X	X
Strategic Objective 1.4 – Recruit, develop and retain a competent health care workforce	X				
Strategic Goal 2 – Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness – Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.					
Strategic Objective 2.1 – Prevent the spread of infectious diseases			X	X	
Strategic Objective 2.2 – Protect the public against injuries and environmental threat					
Strategic Objective 2.3 – Promote and encourage preventive health care, including mental health, lifelong healthy behaviors, and recovery			X	X	X
Strategic Objective 2.4 - Prepare for and respond to natural and man-made disasters	X				X
Strategic Goal 3 – Human Services – Promote the economic and social well-being of individuals, families and communities					
Strategic Objective 3.1 – Promote the economic independence and social well-being of individuals and families across the lifespan				X	X
Strategic Objective 3.2 - Protect the safety and foster the well-being of children and youth			X	X	
Strategic Objective 3.3 – Encourage the development of strong, healthy and supportive communities					
Strategic Objective 3.4 – Address the needs, strengths and abilities of vulnerable populations			X	X	
Strategic Goal 4 – Scientific Research and Development - Advance scientific and biomedical research and development related to health and human services					
Strategic Objective 4.1 – Strengthen the pool of qualified health and behavioral science researchers.					
Strategic Objective 4.2 – Increase basic scientific knowledge to improve human health and development					
Strategic Objective 4.3 – Conduct and oversee applied research to improve health and well-being			X		
Strategic Objective 4.4 - Communicate and transfer research results into clinical, public health and human services practice			X		

Summary of Full Cost

(Allocated Budgetary Resources in Millions)

	CMS		
HHS Strategic Goals and Objectives	**FY 2007**	**FY 2008**	**FY 2009**
1: Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care			
1.1 Broaden health insurance and long-term care coverage.	**$644,010.3**	**$670,536.5**	**$715,586.4**
Benefits	*$632,576.1*	*$659,411.9*	*$703,949.2*
Financial Management	*$9,356.1*	*$9,020.0*	*$9,304.6*
Other Administrative	*$2,078.1*	*$2,104.6*	*$2,332.6*
1.2 Increase health care service availability and accessibility.			
1.3 Improve health care quality, safety, and cost/value.	**$6,255.7**	**$6,006.6**	**$6,227.1**
Quality	*$6,255.7*	*$6,006.6*	*$6,227.1*
1.4 Recruit, develop, and retain a competent health care workforce.			
2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness Prevent and control disease, injury, illness and disability across the lifespan and protect the public from infectious, occupational, environmental, and terrorist threats.			
2.1 Prevent the spread of infectious diseases.			
2.2 Protect the public against injuries and environmental threats.			
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.			
2.4 Prepare for and respond to natural and manmade disasters.			
3: Human Services Promote the economic and social well-being of individuals, families and communities.			
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.			
3.2 Protect the safety and foster the well-being of children and youth.			
3.3 Encourage the development of strong, healthy, and supportive communities.			
3.4 Address the needs, strengths, and abilities of vulnerable populations.			
4: Scientific Research and Development Advance scientific and biomedical research and development related to health and human services.			
4.1 Strengthen the pool of qualified health and behavioral science researchers.			
4.2 Increase basic scientific knowledge to improve human health and human development.			
4.3 Conduct and oversee applied research to improve health and well-being.			
4.4 Communicate and transfer research results into clinical, public health, and human service practice.			
Total	**$650,266.0**	**$676,543.0**	**$721,813.5**

CMS Summary of Full Cost Methodology

Due to the vast purview of the CMS programs, our annual performance goals are representative in nature. Our full cost methodology is based on our previous approach. The full cost estimates included in the Summary of Full Cost table show the funds expended by CMS to support annual performance goals that represent all seven CMS budget programs (Medicare, QIO, HCFAC [MIP], Medicaid, SCHIP, State Grants and Demonstrations, and CLIA). These performance measures are divided by major measure activity (benefits, financial management, quality, and other administrative) for which the total full cost is shown. As the new HHS Strategic Plan is currently structured, our annual performance goals fall primarily under Strategic Goal 1, Objectives 1 and 3.

The chart assumes mandatory budgetary resources equals the amount needed to cover mandatory obligations. Discretionary budgetary resources equals estimated obligations plus estimated user fee obligations. The information in this section is part of a multi-year effort to improve the integration of budget and program performance information.

Full cost data for the measures under each performance program area are shown as non-adds. The sum of full costs of performance measures may not equal the full cost of the performance program area, to the extent the program has elements for which there are no current measures.

List of Program Evaluations

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at http://aspe.hhs.gov/pic/login/index.cfm including program improvement resulting from the evaluation.

Discontinued Performance Measures Tables

Medicare
MCR16

Long Term Goal: Implement Regional PPOs ***(Discontinued after FY 2007)***			
Measure	**FY**	**Target**	**Result**
Implement Regional PPOs **Baseline:** Prior to the Medicare Prescription Drug and Modernization Act (MMA) of 2003, Regional Preferred Provider Organizations (RPPOs) did not exist.	*2008*	Goal discontinued	
	2007	Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 87% of Medicare beneficiaries.	Goal met
	2006	Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 70% of Medicare beneficiaries.	Goal met
	2006	Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 70% of Medicare beneficiaries.	Goal met
Data Source: CMS will monitor and maintain the contract service area and the beneficiary enrollment by service area. These data points will validate the penetration of regional PPOs by service area and the number of beneficiaries enrolled in each plan. This information will also validate the expansion of coordinated care plans and the percentage of enrollees affected by the expansion. To capture these data points, CMS will extract data from the Medicare Beneficiary Database (MBD) and the Medicare Advantage Rx (MARx) database.			
Data Validation: The Health Plan Management System (HPMS) also contains a system of record for plan service areas. CMS validates the plan service areas against the official contract service areas and the Medicare Advantage organizations themselves also validate these service areas.			

Discussion: Prior to 2006, Medicare Advantage (MA) plans, (formerly M+C plans), operated with minimal or no enrollment in most rural areas. The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 expanded the definition of coordinated care plans to include Regional Preferred Provider Organizations (RPPOs). RPPOs were created to facilitate access to the advantages of coordinated care, to all beneficiaries, especially beneficiaries in rural areas. RPPOs, like other PPOs, (1) contract with a network of providers that have agreed with the organization offering the plan, to a contractually specified reimbursement for covered benefits; and (2) reimburse for all covered benefits, provided any place in their service area, regardless of whether such benefits are provided within such a network. The feature distinguishing RPPOs from other PPOs is that they must have a service area that spans one or more entire MA regions. The geographic demarcations of the 26 RPPO regions were established by the Secretary on December 6, 2004.

CMS implemented the RPPO program through coordinated efforts within the agency to ensure timely processing of applications; appropriateness of payments; early availability of outreach

and marketing materials to notify beneficiaries of this new option; availability of scripts and information by the 1-800-MEDICARE line to answer beneficiary questions; and existence of appropriate enrollment mechanisms to ensure that beneficiaries are able to enroll in the program.

CMS met its FY 2006 goal of having Regional Plan options available to 70 percent of the Medicare beneficiary population. CMS met its FY 2007 goal as RPPOs are available as an option to 87 percent of Medicare beneficiaries.

CMS will continue to monitor the penetration of RPPO plans. The ultimate success of RPPOs will depend on the health plans' continued determination that the Regional approach is feasible. The RPPO stabilization fund was created originally as a plan incentive to encourage plan entry into a region in which no plan was operating or for plans to continue in their current region in the face of proposed plan withdrawals. The Tax Relief and Health Care Act of 2006 reduced the stabilization fund to $3.5 billion and delayed the use of the fund until 2012, limiting CMS' ability to encourage or maintain future RPPO participation.

MCR17

Long Term Goal: Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities ***(Discontinued after FY 2007)***			
Annual Measure	**FY**	**Target**	**Result**
Developed and implemented a measure to allocate State survey and certification funding in a manner that links value to quality performance. (*outcome*)	*2008*	Goal retired.	
	2007	Continue ongoing effort in State Survey and Certification budget allocation methods by; **1. <u>Allocations</u>**: Allocate at least 75% of any survey & certification resource increase primarily according to the workload-sensitive Budget Allocation Tool (BAT). **2. <u>Non-Delivery Deductions</u>**: For states that fail to accomplish 100% of the statutorily-required surveys, deduct at least 75% of the average estimated cost of the non-delivered surveys from the agency's next-year budget allocation	Goal met
Implement Budget Allocation Method	*2006*	Implement a State Survey and Certification budget allocation method	Goal met
	2005	Continue to develop a State Survey and Certification budget allocation method	Goal met
	2004	Develop a State Survey and Certification budget allocation method that allocates available resources for State agencies in a manner that promotes high levels of State performance and value-based purchasing of survey activities on the part of CMS.	Goal met
Baseline: Developmental			
Data Source: Information on State performance reviews are obtained from the CMS/CMSO National Performance Standards Report. Workload data is obtained from State-reported OSCAR 670 data and State Survey and Certification Workload Reports (Form HCFA-434). The budget, expenditures, and baseline data are obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.			
Data Validation: OSCAR 670 data are validated annually as part of annual onsite surveys. Form HCFA-434 and Form HCFA-435 data are validated by CMS reviews. State Agency performance reviews are conducted by CMS each fiscal year.			
Cross Reference: This performance goal supports goals 5 and 8 of the HHS Strategic Plan, the President's Management Agenda and links to the Secretary's 500-Day Plan.			

Discussion: The primary mission of CMS' survey and certification program is to ensure that the nation's elderly and people with disabilities receive high quality care and adequate protections. CMS has a responsibility to purchase high value survey services, verify that the survey services are performed as contracted, and assess the quality of the survey services performed.

CMS is committed to increased focus on the assurance of purchasing quality, value, and performance in State survey and certification activities. The foundation of this commitment and focus is based on the recent development and broadening of the standards to include other provider types outside of long-term care, as well as the successful CMS efforts (since FY 2001) in

meeting this performance measure: Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities.

To accomplish its objectives, CMS began to move from a price-based budget development and execution model to a value-based model. In 2001 through 2004, increases to the State survey and certification budget were allocated using price-based boundaries: States only received a budget increase if their average hours per survey were within 115 percent of the national average. Moreover, CMS has designed and implemented a system of State performance indicators for survey and certification activities. Seven (7) performance measures were implemented in FY 2001 on a test basis, were fully deployed in 2002, and further refined in 2003, 2004, and 2005.

In 2006 and 2007, in our continuing efforts to improve and fairly assess whether the SAs fulfill their responsibilities under the 1864 agreement, we implemented changes that would ensure that all States would be evaluated in a consistent manner, and that they would have the ability to monitor their own processes before problems occur. In 2007, CMS monitored the frequency with which survey teams provide onsite, objective, and outcome-based verification that basic standards of quality are met by providers; the quality of the surveys themselves; and the appropriateness and effectiveness of enforcement actions taken.

Actual performance data for 2002 - 2006 activities have been collected and analyzed. Moving forward, we are using such available performance data to develop and implement a measure that moves toward the linking of value and performance to bolster the importance of the quality of surveys; the overall State performance in completing the required number and frequency of surveys; and the effective performance of State survey agencies in taking remedial action on complaints and deficiencies. CMS met its FY 2004, FY 2005, FY 2006, and FY 2007 targets to develop a State Survey and Certification budget allocation method for State agencies.

HCFAC (MIP)
MIP5

Long Term Goal: Decrease the Medicare Provider Compliance Error Rates ***(Discontinued after FY 2007)***			
Measure	**FY**	**Target**	**Result**
Decrease the Provider Compliance Error Rates by 20 percent over the previous fiscal year's level. (*outcome*) **Baseline:** See the Carrier-specific and Durable Medical Equipment Regional Carriers (DMERC)-specific provider compliance error rates (including non-response claims) listed in Tables 7 and 8 of the FY 2004 Improper Medicare Fee-for-Service Payment Report.	*2008*	Goal discontinued.	Goal discontinued
	2007	Developmental. Revise methodology	Goal not met.
	2006	20% decrease for Carriers & DMERCs	Goal not met.
	2005	20% decrease	Goal partially met
	2004	Set baseline	Goal met
Data Source: Contractors receive a semi-annual error rate report from the CERT contractors and can use the information on a monthly basis to look for trends and outliers.			
Data Validation: The OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.			
Cross Reference: This performance goal supports the President's Management Agenda, goal 1 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The Provider Compliance Error Rate is based on the compliance of submitted claims with Medicare rules and requirements before any reviews or edits are applied by the contractor. The provider compliance error rate is intended to show how well the contractors are educating the provider community since it measures how well providers prepared claims for submission. The sampled claims are subjected to detailed medical review and a compliance error rate is calculated based upon the dollar value ratio of claims submitted improperly to total claims.

However, since its inception, the error rate calculation methodology has changed several times. As well, the purpose and use of the provider compliance error rate has proven to be confusing to contractors and the public. In fact, the CERT program has identified several situations where a provider compliance error is being imposed and either the provider is doing everything correctly or there is nothing the contractor can do to prevent it. Therefore, CMS is discontinuing this performance measure after FY 2007. CMS has not been able to develop a meaningful methodology for calculating the provider compliance error rate. We have been unable to devise a way to systematically exclude factors that are outside our control e.g., fraudulent billing.

State Children's Health Insurance Program (SCHIP)
SCHIP1

Long Term Goal: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid

Efficiency Measure	FY	Target	Result
Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid **Baseline:** In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid, and none in SCHIP	*2008*	Goal discontinued	N/A
	2007	Maintain enrollment at FY 2005 levels.	Mar-08
	2006	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3%, or approximately 1,000,000 over the previous year.	Goal not met
	2005	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3%, or approximately 1,000,000 over the previous year.	Goal met
	2004	Maintain enrollment at FY 2003 levels.	Goal met
	2003	Increase enrollment 5% over 2002.	Goal met
	2002	Increase enrollment 1,000,000 over 2001.	Goal met

Data Source: States are required to submit quarterly and annual State Children's Health Insurance Program statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly on unduplicated counts of the number of children under age 19 who are enrolled in separate SCHIP programs, Medicaid expansion SCHIP programs, and regular Medicaid programs. The enrollment counts presented in this update are the sum of the unduplicated number of children ever enrolled in separate SCHIP programs, Medicaid expansion SCHIP programs, and regular Medicaid programs during the year.

The estimate of 21,000,000 for Medicaid enrollment for FY 1997 is based on CMS-2082 data edited by The Urban Institute and published in December 1999. Although CMS previously reported a 1997 baseline of 22,700,000 children enrolled in Medicaid, this was based on unedited CMS-2082 data and incomplete data reported by the States through SEDS. CMS and the States consider the 21,000,000 Medicaid enrollment figure to be a final estimate for 1997. This figure is also cited in the first annual report of the CMS-funded evaluation of SCHIP by Mathematica Policy Research (posted on the web at http://www.cms.hhs.gov/schip/sho-letters/mpr12301.asp).

The 2004-2006 Medicaid enrollment counts presented are estimates based on interim data submitted by the States through SEDS and are therefore subject to change when edited CMS-2082 data become available. In general, edited data for a fiscal year are available about two years after the end of the year. Capturing enrollment data for Medicaid children is also a challenge, because States do not always report Medicaid data as timely in SEDS as SCHIP enrollment data.

Data Validation: CMS will measure, to the extent possible, the unduplicated count of the number of children who are enrolled in any of the following programs: regular Medicaid; expansions of Medicaid through SCHIP; and separate SCHIP programs as reported by the States.

Cross Reference: The performance goal supports HHS Strategic Goal 1 and the President's Management Agenda, and is linked to the Secretary's 500-Day Plan.

Discussion: The purpose of SCHIP as stated in Title XXI of the Social Security Act is, "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children." Consistent with this purpose, and to affirm our commitment to decreasing the number of uninsured children, CMS has established this goal to increase the number of children enrolled in SCHIP and Medicaid. Enacted through the Balanced Budget Act of 1997, SCHIP, under Title XXI of the Social Security Act, allocates nearly $40 billion over 10 years to extend health care coverage to low-income, uninsured children. This program represents the largest single expansion of health insurance coverage for children in more than 30 years and aims to improve the quality of life for millions of vulnerable children less than 19 years of age. As of September 1999, all States, territories and the District of Columbia had approved SCHIP plans in place. SCHIP enables States to establish separate SCHIP programs, expand existing Medicaid programs, or use a combination of both approaches.

While this goal focuses on enrolling children in Medicaid and SCHIP rather than on measuring uninsurance rates, there is overwhelming evidence that the rate of uninsurance in children has been reduced since the inception of SCHIP. Although estimates of insurance coverage for children vary, the U.S. Census Bureau's Current Population Survey (CPS) is the most widely cited source. The most recent CPS data (three-year rolling average for FYs 2003-2005) suggested that there were approximately 5.5 million children under the age of 19 at or below 200 percent of the Federal poverty level (FPL) who lacked health insurance coverage, down from over 7.5 million in 1997 (three-year rolling average for FYs 1996-1998). In addition, while the percent of individuals with health insurance for all ages dropped only slightly from 1997-2005 (15.4 percent - 14.9 percent) the percentage of uninsured children dropped from 13.9 percent in 1997 to 8.9 percent in 2005. An analysis of 2004 CPS data conducted by the Urban Institute[1] determined that less than 1.1 million children were Medicaid or SCHIP eligible, but uninsured. The best available data show 21 million children ever enrolled in Title XIX Medicaid during FY 1997 (before the inception of SCHIP).

According to the Statistical Enrollment Data System (SEDS), more than 6.6 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) and 29.6 million children participated in regular Medicaid in FY 2006, for a combined total of 36.2 million children. This represents an increase in SCHIP enrollment of 8.2 percent over FY 2005 enrollment and a decrease in Medicaid enrollment of 2.6 percent from the same period. Thus, the total enrollment decreased by 300,000 children, or 0.8 percent, which does not meet the established target.

We attribute this leveling of combined program enrollment growth to several factors. First, States' economic situations and corresponding changes to their Medicaid State plans- a few States made changes to their Medicaid eligibility requirements- caused a slight decrease in enrollment. Also, the FY 2005 enrollment numbers reported in March 2006 contained CMS-estimated Medicaid enrollment numbers for several States that had not reported through SEDs. These estimates, which were derived using an actuarially determined growth rate, may have artificially inflated the FY 2005 combined enrollment, yielding a larger base on which the 3 percent increase in FY 2006 enrollment was to be attained. Finally, the combined enrollment has increased so much since the enactment of this goal, resulting in the denominator becoming

[1] The Urban Institute conducted an analysis of Medicaid and SCHIP eligibility among the uninsured using the Transfer Income Model, version 3 (TRIM3). In determining program eligibility, the simulation used State-specific eligibility levels, rather than 200 percent of the Federal poverty level.

so large, that showing a full percentage point increase in enrollment would require significant increases in enrollment in both programs.

Future enrollment (and associated increases in enrollment) in Medicaid will be affected by States' programmatic changes. SCHIP enrollment will undoubtedly be affected by SCHIP reauthorization-associated programmatic changes or changes in funding levels.

Year	Children Served by SCHIP (Title XXI)*	Children Served by Medicaid (Title XIX)*	Total Number of Children Served by SCHIP & Medicaid *	Yearly Increase in Number of Children Served by SCHIP & Medicaid	GPRA Target *(yearly increase in number of children served by SCHIP and Medicaid)*
1997	0	21,019,000 [2]	21,019,000	---	
1998	980,000	20,200,000	21,180,000	161,000	
1999	2,000,000	20,600,000	22,600,000	1,400,000	
2000	3,400,000	22,000,000	25,400,000	2,800,000	1,000,000
2001	4,600,000	*23,400,000*	*28,000,000*	*2,600,000*	1,000,000
2002	5,400,000	*25,900,000*	*31,300,000*	*3,300,000*	1,000,000
2003	6,000,000	*27,100,000*	*33,100,000*	*1,800,000* (6% increase)	5% (1,520,000)
2004	*6,100,000*	*29,300,000*	*35,400,000*	*2,300,000* (7% increase)	Maintain
2005	*6,100,000*	*30,400,000*	*36,500,000*	*1,100,000* (3.1% increase)	3% or (1,000,000)
2006	*6,600,000*	*29,600,000*	*36,200,000*	(300,000) (0.8% decrease)	3% or (1,000,000)
2007	--	--	--	March 2008	Maintain FY2005 enrollment

[2] Ku, Leighton and Brian Bruen, "The Continuing Decline in Medicaid Coverage," December 1999.

*Based on most recent data available as of June 2007.

Note: Italicized figures are estimates based on incomplete Title XIX data submitted by the States. Also, these numbers reflect new information compared to previous publications. Enrollment data previously published for some States may have been based on estimates rather than final State-reported data. In the case of Medicaid data, a number of States did not report Medicaid enrollment in SEDS until recently. Therefore, estimates were initially used, based on other historical Medicaid data. As final data become available, those Medicaid estimates are updated. In addition, some States report preliminary data for their quarterly reports, and refine those numbers as final data become available. For example, States that have retroactive eligibility update enrollment for previous quarters. For any State that is delayed in reporting enrollment data, estimates for this goal are used based on either the previous years' data for that State or data submitted through Medicaid Statistical Information System reporting until final data is reported in SEDS.

Data Source and Validation Table Template

Unique Identifier	Data Source	Data Validation
	Medicare	
Beneficiary Satisfaction MCR1	The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in all Medicare Advantage plans and in the original Medicare fee-for-service plan.	The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 2.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.
Appeals MCR2	The Medicare Advantage Organization provides the IRE with appeals data to enable the IRE to report and maintain aggregate data in its system. The IRE ultimately will report data into the MAS. Aggregate FFS data are entered into the Contractor Reporting of Operational Workload Data (CROWD) system by FIs, carriers, and Medicare Administrative Contractors. The Medicare Appeals System tracks FFS data for the level two Qualified Independent Contractors and level three Administrative Law Judges.	CMS utilizes the Contractor Performance Evaluation (CPE) process to evaluate the performance of FIs and carriers.
Medicare Prescription Drug Plan MCR3	For beneficiary surveys, the data source is surveys with nationally-representative samples of beneficiaries. For enrollment, the data source is the Management Information Integrated Repository (MIIR) that receives data through MARx plus external source of enrollment for FEHB Retiree Drug Coverage, Tricare Retiree Coverage, VA Coverage, Indian Health Services Coverage, Active Workers with Medicare Secondary Payer, Other Retiree Coverage, and State Pharmaceutical Assistance Program. The external sources of data are aggregate numbers of coverage and are not at the beneficiary level.	For beneficiary surveys, these items have been extensively tested with Medicare beneficiaries and the surveys have been tested for reliability and validity. These surveys are subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device. For enrollment, the data from MIIR is updated weekly from the MARx system – the system through which Part D plans report enrollment.
Physical Restraints MCR4	CMS reports physical restraints rates using the Quality Measures derived from the Minimum Data Set (MDS-QM). Nursing homes submit this information to the State MDS database, which is linked to the national MDS database. The physical restraints quality measure used is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. We report the prevalence of physical restraints that are used continuously for at least one week, excluding side rails, in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. Restraints counted on admission assessments are excluded.	The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

Unique Identifier	Data Source	Data Validation
Pressure Ulcers MCR5	Prior to FY 2004, CMS reported the prevalence of pressure ulcers with Minimum Data Set (MDS) - Quality Indicator (QI) scores. In FY 2004, a change was made to using the quality measures (QMs) derived from the Minimum Data Set (MDS) to measure the prevalence of pressure ulcers in long term care facilities. Nursing homes submit this information to the State MDS database, which is linked to the national MDS database. The measure being used for the pressure ulcer goal is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. For this goal, we report the prevalence of pressure ulcers measured in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. The numerator consists of all residents with a pressure ulcer, stages 1-4, on the most recent assessment and the denominator is all residents. Pressure ulcers counted on admission assessments are excluded.	The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS has renewed contract effort to develop protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.
Nursing Home Surveys MCR6 & **Home Health Surveys** MCR7	Information on State performance is obtained from the CMS/CMSO National Performance Standards Data Base. The baseline data was determined using FY 2005 Admin Info Memorandum 05-07 which provided allocated 2005 monies with non-delivery deductions based on 2003-2004 non-performance.	Under the State Performance Standards system, CMS reviews annually whether the State Survey Agencies are entering this data in a timely manner.
Non-Delivery Deduction MCR8	Information on State performance reviews are obtained from the CMS/CMSO National Performance Standards Report. Workload data is obtained from State reported OSCAR 670 data and State Survey and Certification Workload Reports (Form-HCFA-434). The budget, expenditures, and baseline data are obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels. The baseline data was determined using FY 2005 Admin Info Memorandum 05-07 which provided allocated 2005 monies with non-delivery deductions based on 2003-2004 non-performance.	OSCAR 670 data are validated annually as part of annual on-site surveys. Form HCFA-434 and Form-435 data are validated by CMS reviews. State Agency performance reviews are conducted by CMS each fiscal year.
Beneficiary Telephone Customer Service MCR9	As reviewers/auditors monitor a sample of calls for each customer service representative, they record the assessment of performance on standardized Quality Call Monitoring scorecards. Criteria for rating all aspects of call handling are also standardized. Accuracy and overall quality of the calls handled in Beneficiary Contact Centers (BCC) are reported daily to the CMS National Data Warehouse (NDW) for ad hoc reporting and internal monitoring of performance by the BCC. An official roll-up report is provided by the NDW to CMS on a monthly basis.	The BCC reporting is reviewed on a regular basis by CMS for compliance with established standards. CMS plans to validate the data on accuracy of response by having an Independent Quality Assurance contractor sample and review calls handled by the BCC contractor.
Payment Timeliness MCR10	The primary data source is the Contractor Reporting of Operational and Workload Data (CROWD) system. CROWD contains contractor-specific bills/claims processing timeliness rates. Success in achieving the desired target will be measured at the national level.	CMS routinely utilizes Contractor Performance Evaluation (CPE) and Quality Assurance Surveillance Plans (QASP) for determining whether intermediaries and carriers are meeting claims processing timeliness requirements. Through CPE and QASPs, CMS measures and evaluates Medicare contractor performance to determine compliance with specific responsibilities defined in the contract with CMS, and also responsibilities outlined in Medicare law, regulations, and instructions.

Unique Identifier	Data Source	Data Validation
Electronic Commerce MCR11	The data source for tracking EMC and other data is CMS' Contractor Reporting of Operational and Workload Data (CROWD) system. Medicare contractors started to separately report to CMS on status of HIPAA standards implementation and testing in FY 2002. In FY 2003, collection of baseline data for carriers began through the CROWD system for EDI transactions in addition to claims. Collection of similar data for intermediaries began in FY 2004. In FY 2006, CMS started collecting additional data for transactions covered by HIPAA that are processed by means other than EDI (e.g. telephone) to assess the overall impact of EDI on program costs to conduct these functions. In FY 2007, CMS collected data on all HIPAA covered transactions that were implemented for Medicare Fee-For-Service operation.	CMS routinely utilizes the Contractor Performance Evaluation (CPE) for evaluating the accuracy of contractor data reporting, including CROWD, and investigates outliers reported in any given month. Review and analysis of monthly statistics helps identify where corrective action is needed, and assess when educational articles might be helpful. The CPE measures and evaluates contractor performance to determine if contractors meet specific responsibilities defined in the contract between CMS and the contractor, and also responsibilities outlined in Medicare law, regulations, and instructions.
CFO Report MCR12	The annual audit opinion for CMS' financial statements is issued by a CPA firm with oversight by the OIG.	The CMS works closely with the OIG and CPA firm during the audit and has the opportunity to review, discuss, and/or clarify the findings, conclusions, and recommendations presented. The Government Accountability Office has the responsibility for the opinion on the consolidated government-wide financial statements, which includes oversight for the audit of HHS, of which CMS' outlays are a vast majority.
Contracting Reform MCR13	Data on fee-for-service claims contractor workload is available through CMS' current reporting systems. CMS will present progress reports on Medicare Contracting Reform to the Department of Health & Human Services, the Office of Management & Budget, and Congress on a regular basis. CMS' contract office will notify the public of MAC contract opportunities and awards in accordance with FAR.	CMS staff will review all reports with cited data to ensure that the reports are accurate, complete and understandable.

Unique Identifier	Data Source	Data Validation
Enterprise Architecture MCR14	Approved standards and preferred IT products are documented in the CMS Target Technical Architecture document, (http://www.cms.hhs.gov/SystemLifecycleFramework/Downloads/TargetArchitecture.pdf) All IT policies and subordinate documents are published in the Framework, (http://www.cms.hhs.gov/SystemLifecycleFramework) a comprehensive library of all information relating the acquisition and creation of IT systems. A mechanism for measuring architecture maturity will be data in the Enterprise Architecture Repository (http://www.cms.hhs.gov/EnterpriseArchitecture/02_FEAF.asp)	Compliance with the CMS EA standards and practices is monitored through checkpoints in the Framework that document when and where in the procurement and system development lifecycle EA reviews must take place.
CMS Workforce Diversity MCR15	• Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 2000 official decennial census figures[3] • The 2000 official decennial census figures • OPM's Central Personnel Data File (updated every pay period) • HHS' Workforce Inventory Profile System (WIPS) (updated every pay period) • The CMS Workforce Profiles (prepared using WIPS)	• 2000 Civilian Labor Force data - Validated and verified by the Census Bureau • Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 2000 official decennial census figures - Validated and verified by OPM. These are the standard government-wide statistics. • Central Personnel Data File - Validated and verified by OPM. • HHS' Workforce Inventory Profile System (WIPS) - Validated and verified by HHS. • The CMS Workforce Profiles – Validated and verified by CMS.
Medicaid		
Medicaid/ SCHIP Payment Error Rate MCD1	Data Source: National contracting strategy gathers adjudicated claims data and medical policies from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State.	CMS, The Lewin Group and Livanta LLC are working with the 17 States to ensure that the Medicaid universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.
Medicaid Quality Strategy MCD2	States report quality improvement efforts via several vehicles including the State quality improvement strategies (CFR 438.204 Subpart D), External Quality Review Organizations (EQRO) Reports (CFR 438.310-438.70 Subpart E), Home and Community Based Services (HCBS) Waiver Quality Assessment reports (CFR 441.301- 441.303, 441.308, 447.200, 447.431), Medicaid Demonstration evaluation reports, performance measurement reporting, State report cards, clinical studies, targeted Performance Improvement Projects, and other vehicles. A combination of these data sources will be analyzed, when available and appropriate, to ensure a comprehensive review of State quality improvement activities.	CMS has developed templates, assessment tools and protocols for review and validation of quality improvement strategies, selected EQRO requirements, and program evaluations.
Medicaid Managed Care Organizations and Health Insuring Operations MCD3	Medicaid Managed Care Enrollment Report - The report is composed annually, using States reported data by CMS	The information is collected from State Medicaid Agencies with the assistance of CMS Regional Offices. Data validation is a joint effort of CMS Central and Regional Offices. Regional Offices are responsible for thoroughly reviewing and validating the data before submitting to Central Office which performs the final review and validation.

[3] EEOC Office of Federal Sector Programs requires agencies to use current, official Census Bureau Civilian Labor Force data to analyze the Federal workforce.

Unique Identifier	Data Source	Data Validation
Home and Community-Based Services MCD4	Medicaid Statistical Information System (MSIS) – States submit quarterly files to CMS with demographic and eligibility characteristics on each individual in Medicaid, their service utilization and payments made for those services. The numerator is the number of beneficiaries who receive home and community-based services. The denominator is the total number of beneficiaries eligible for institutional level of care.	MSIS data are submitted to CMS on 5 different files, an eligibility file and four files of claims: inpatient, long-term care, drugs and all other claims. The data files are subjected to quality assurance edits to ensure that the data are within acceptable error tolerances and a distributional review which verifies the reasonableness of the data. CMS contractors work directly with state staff to correct the data to ensure the files are accurate. The data are warehoused in CMS and a State Summary Data Mart provides users access to the information. Use of the data ensures the quality of cross State statistics.
1115 Waivers MCD5	CMS project officers conduct reviews of Section 1115 demonstration budget neutrality data.	Section 1115 demonstrations are monitored for compliance by CMS through quarterly, annual, and ad hoc reports from the States. In addition, the GAO periodically conducts reviews of Section 1115 demonstrations.
Medicaid Integrity Program MCD6	Data Source: Developmental. The Medicaid Integrity Contractors (MICs) will compile the data for the return on investment calculation during audits where overpayments are identified and recouped.	Data will be validated through CMS oversight of the MICs.
State Children's Health Insurance Program (SCHIP)		
SCHIP Health Quality SCHIP2	Developmental. Beginning in FY 2003, CMS began collecting SCHIP performance measures through the SCHIP annual reports. In addition, CMS created an automated web-based system – State Annual Report Template System (SARTS), which allows States to input and submit their annual reports to CMS via the internet. This system also allows CMS to better analyze data submitted by States, including monitoring the progress States are making toward meeting their individual goals related to the SCHIP core performance measures. States began reporting in SARTS, on a voluntary basis, for the SCHIP FY 2003 Annual Reports. In 2003-2004, two States were piloted for assessing ability to report performance measurements via administrative data in the Medicaid Statistical Information System (MSIS). States were supportive of the effort, but continued to implement performance measures via other mechanisms, such as the Health Plan Employer Data and Information Set (HEDIS®) reporting. In 2005, performance measures publicly reported from ten States were evaluated in conjunction with State quality improvement initiatives.	Developmental. CMS will monitor performance measurement data related to the SCHIP core performance measures through SARTS. In addition, State performance data submitted through SARTS will be monitored to assure that individual State goals are consistent with the approved Title XXI SCHIP State plan. In 2004, validity testing was performed on use of MSIS administrative data for performance measurement reporting, and was found not to be reliable in producing accurate results at the time.
SCHIP Enrollment SCHIP3	States are required to submit quarterly and annual SCHIP statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly and annually on unduplicated counts of the number of children under age 19 who are enrolled in separate SCHIP programs and Medicaid expansion SCHIP programs. The enrollment counts presented reflect an unduplicated number of children ever enrolled during the year in separate SCHIP and Medicaid expansion SCHIP programs.	CMS will measure, to the extent possible, the unduplicated number of children enrolled during the year in expansions of Medicaid through SCHIP and separate SCHIP programs as reported by the States.
Health Care Fraud and Abuse Control (Medicare Integrity Program)		

Unique Identifier	Data Source	Data Validation
FFS Error Rate MIP1	Comprehensive Error Rate Testing (CERT) Program. CMS assumed responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG. Error rate information for years preceding the FY 2003 report was compiled by the OIG.	The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.
Provider Enrollment Process MIP2	The Provider Enrollment, Chain and Ownership System (PECOS)	We use annual contractor performance evaluation protocol to assess Medicare contractor provider enrollment performance. PECOS data will be verified during annual, onsite surveys of contractors and through reports available from PECOS.
Voluntary Data Sharing Agreements MIP3	CMS receives the Medicare Secondary Payer (MSP) data from those entities that currently have a VDSA with CMS. The employer/insurer sends its files to the COB Contractor for processing in the prescribed CMS format, and files containing information on covered working individuals are transferred to CMS. Each file submission results in a unique response file being sent back to the employer that includes basic Medicare entitlement data. As of December 2005, CMS began collecting prescription drug coverage information that is primary and secondary to Medicare from these same sources, as well as Pharmacy Benefit Management companies.	The COB Contractor edits and validates the data received by the employers/insurers through multiple independent processes before uploading any new MSP information to the Common Working File or, in the case of drug records, to the Medicare Beneficiary Database. These are two CMS databases used in the claims adjudication process. All records with an error are identified and sent back to the employer/plan indicating why the record could not be processed. Records that do not contain errors are processed accordingly.
Contractor Error Rate MIP4	Contractors receive a semi-annual error rate report from the CERT contractors and can use the information on a monthly basis to look for trends and outliers.	The OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.
State Grants and Demonstrations		
Medicaid Infrastructure Grant Program SGD1	CMS uses internal information on grant award amounts and grant types; Medicaid Buy-In enrollment submitted by MIG states; data supplied by states through quarterly progress reports; employment and earnings records from the Social Security Administration (SSA); and nationally representative survey data as well as administrative claims data on employment rates for people with disabilities.	Reports are complied using a cadre of large national data base sources. These statistical data bases are validated internally by the respective state/federal agency data and research personnel.
Clinical Laboratory Improvement Act		
Cytology Testing CLIA1	Access database developed and managed by CMS. This database will monitor all laboratories performing gynecologic cytology testing, proficiency testing enrollment information, and performance results. Because this proficiency program is testing specific personnel, every individual who examines or interprets gynecologic cytology slides will be listed according to his/her employment site(s). Enrollment and performance data will also be maintained on an individual basis.	CMS Central Office (CO) will maintain access of this database. Regional Office and State Agency representatives will be contacted directly by CO in the event of performance issues. The PT programs that provide the samples undergo an annual and ongoing review process coordinated by CMS with assistance from the Centers for Disease Control and Prevention, e.g., the PT data system and PT programs are monitored to ensure that PT data transmitted to CMS is accurate, complete, and timely.
Quality Improvement Organizations		
Influenza/ Pneumococcal Vaccination QIO1	The Medicare Current Beneficiary Survey (MCBS), an ongoing survey of a representative national sample of the Medicare population, including beneficiaries who reside in long-term care facilities.	The MCBS uses Computer Assisted Personal Interview (CAPI) technology to perform data edits, e.g., range and integrity checks, and logical checks during the interview. After the interview, consistency of responses is further examined and interviewer comments are reviewed.

Unique Identifier	Data Source	Data Validation
Mammography QIO2	The National Claims History (NCH) file is the data source used to track the mammography goal. The percentage of women age 65 and older with paid Medicare claims for mammography services during a biennial period will be calculated. The denominator consists of women who are enrolled in both Parts A and B on an FFS basis. Medicare beneficiaries who are enrolled in an HMO for more than a month in either year of the biennial period are not be included in the rate calculation.	The NCH is a 100 percent sample of Medicare claims. Claims submitted by providers to Medicare are checked for completeness and consistency. Duplicates are eliminated to ensure that women who have more than one mammogram within the two-year period do not contribute to over counting. Mammography utilization rates for age groups, race and counties are calculated and compared to previous years' data to check for any unusual changes in data values.
Diabetic Blood Tests QIO3	The National Claims History (NCH) file will be the primary data source. A systematic sample of patients aged 18-75 years who had a diagnosis of diabetes (type 1 and 2) with paid Medicare claims for HbA1c and LDL testing during the measurement year or year prior to the measurement year will be calculated. The denominator for each performance measure will consist of diabetic patients who had two face-to-face encounters with different dates of services in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year. The measurement period will be for one year, January 1-December 31.	The NCH is a 100 percent sample of Medicare claims submitted by providers to Medicare and is checked for completeness and consistency. Utilization rates for age groups, race and gender are calculated and compared to previous years' data to check for any unusual changes in data values.
Surgical Site Infection QIO4	Baseline State-level performance rates are calculated using self-reported and validated data abstracted from hospitals participating in the CMS Annual Payment Update program. This data collection follows our previous plans to use methods that reflect the evolution of CMS quality improvement activities toward public reporting at the hospital level.	The accuracy and reliability of data from the QIO Clinical Warehouse are monitored constantly through reabstraction of a sample of medical records by the CMS Data Abstraction Center (CDAC) for each hospital that submits at least 6 cases to the Warehouse each quarter.
Vascular Access QIO5	Data submitted by the dialysis facilities. Large dialysis facilities submit directly to CMS through a file transfer. The 18 ESRD Networks collect data from independent dialysis facilities. (The baseline data includes 75% of independent facilities. We are moving toward 100% submittal by independent facilities.)	Through the ESRD Clinical Performance Measures (CPM) project, ESRD Network staff will re-abstract the vascular access data from the records of a sample of patients to ensure that dialysis facilities are reporting data accurately.