DEPARTMENT of HEALTH and HUMAN SERVICES

Centers for Medicare & Medicaid Services

FY 2008 Annual Performance Report

Introduction *(appears in inside cover)*

This FY 2008 Annual Performance Report provides information on the Centers for Medicare & Medicaid Services' actual performance and progress in achieving the goals established in the FY 2008 Annual Performance Plan which was published in February 2007.

The goals and objectives contained in this document support the Department of Health and Human Services' Strategic Plan (available at http://aspe.hhs.gov/hhsplan/2007/).

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Annual Performance Report for fiscal year (FY) 2008. CMS is the largest purchaser of health care in the United States, serving about 92 million Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) beneficiaries. We take this role very seriously, as our oversight responsibility impacts millions of lives and has grown dramatically over the last few years.

CMS highlights performance measures that are representative of our agency's broad focus and is committed to program improvement and performance reporting. This Annual Performance Report also reflects the agency's progress on improving program effectiveness based on the recommendations contained in the Office of Management and Budget's Program Assessment Rating Tool (PART) assessments for Medicare, SCHIP, the Medicare Integrity Program, and Medicaid.

To the best of my knowledge, data used to measure each performance goal are accurate, complete and reliable, and there are no material inadequacies with the data presented.

On behalf of our beneficiaries, I thank you for your interest in the CMS FY 2008 Annual Performance Report.

(signed)
Kerry N. Weems

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

FY	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	% Met
2005	49	49	100%	39	80%
2006	45	45	100%	42	93%
2007	46	46	100%	42	91%
2008	53	36	68%	31	86%
2009	52	n/a	n/a	n/a	n/a

Medicare Operations

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long-Term Objective: Improve Medicare's Administration of the Beneficiary Appeals Process – Medicare Fee-For-Service (FFS), Medicare Advantage, and Medicare Prescription Drug Program								
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	Enhance MAS function-ality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases
MCR 2.2	Medicare Advantage: Enhance MAS functionality and support major maintenance releases	Goal Met Began integrating IRE data reporting into the MAS function-ality	Goal Met Fully integrated IRE data reporting into the MAS	Enhance MAS function-ality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases
MCR 2.3	Fee-for-Service: Enhance MAS functionality and support major maintenance releases	Goal Met Developed the second increment of the MAS	Goal Met Developed the third increment of the MAS	Enhance MAS function-ality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases	Goal Met	Enhance MAS function-ality and support major main-tenance releases
Long Term Objective: Implement the Medicare Prescription Drug Benefit								
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	67%	62%	Goal Met 63%	63%	Goal Met 64%	Measure Dis-continued
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	69%	64%	Goal Met 69%	65%	Goal Met 75%	71%
MCR 3.1c	Beneficiary Survey Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs	N/A	50%	45%	Goal Met 68%	46%	Goal Met 69%	60%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
MCR 3.2	Program Management / Operations	N/A	Goal Met Implemented a Part D Claims Data System, oversight system, and contractor management system	Publish Part D sponsor performance metrics on the Medicare Prescription Drug Plan Finder (MPDPF) tool	Goal Met Published Part D sponsor performance metrics on the MPDPF tool	Publish the 2007 report card of Part D plan sponsor performance	Goal Met Published the 2007 report card of Part D plan sponsor performance	Add "Patient Safety" measures and refresh all report card measures
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	90%	91%
Long Term Objective: Decrease the Prevalence of Restraints in Nursing Homes								
MCR 4	Decrease the prevalence of restraints in nursing homes	Goal met. 6.6%	Goal met. 6.1%	6.2%	5.0%	6.1%	Feb-09	5.1%
Long Term Objective: Decrease the Prevalence of Pressure Ulcers in Nursing Homes								
MCR 5	Decrease the prevalence of pressure ulcers in nursing homes	Goal met. 8.5%	Goal met. 8.2%	8.6%	8.1%	8.5%	Feb-09	8.2%
Long Term Objective: Percentage of States That Survey Nursing Homes At Least Every 15 Months								
MCR 6	Percentage of States that survey nursing homes at least every 15 months	Baseline 66%	N/A	N/A	N/A	80%	Mar-09	85%
Long Term Objective: Percentage of States That Survey Home Health Agencies (HHAs) At Least Every 36 Months								
MCR 7	Percentage of States that survey HHAs at least every 36 months	Baseline 42%	N/A	N/A	N/A	70%	Mar-09	75%
Long Term Objective: Percentage of States for Which CMS Makes A Non-Delivery Deduction From the State's Subsequent Year Survey and Certification Funds								
MCR 8	Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds	Baseline 6%	N/A	N/A	N/A	70%	Goal Met 75%	75%
Long Term Objective: Improve Beneficiary Telephone Customer Service								
MCR 9.1a	Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act	98%	93%	90%	95%	90%	Goal Met 97%	90%
MCR 9.1b	Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment	98%	97%	90%	97%	90%	Goal Met 94%	90%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
MCR 9.1c	Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	98%	94%	90%	94%	90%	Goal Met 94%	90%
MCR 9.2	Maintain and continue to develop Virtual Call Center Strategy (VCS) initiatives for handling beneficiary inquiries	Goal Met Main-tained Quality Standard from the previous fiscal year	Goal Met Main-tained and continued to develop VCS initiatives for handling beneficiary inquiries	Maintain and continue to develop VCS initiatives for handling beneficiary inquiries	Goal Met Main-tained and continued to develop VCS initiatives for handling beneficiary inquiries	Maintain and continue to develop VCS initiatives for handling beneficiary inquiries	Goal Met Main-tained and continued to develop VCS initiatives for handling beneficiary inquiries	Measure dis-continued
Long Term Objective: Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements								
MCR 10.1	Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Fiscal Intermediaries	99.9%	99.8%	95%	99.8%	95%	Goal Met 99.8%	95%
MCR 10.2	Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Carriers	98.4%	99.5%	95%	99.0%	95%	Goal Met 98.8%	95%
Long Term Objective: Increase the Use of Electronic Commerce/Standards in Medicare								
MCR 11.2a	Electronic Remittance Advice Rates for FIs	Completed analysis of baseline data	53.27%	55%	Goal Met 58.14%	59%	Goal Met 59.68%	60%
MCR 11.2b	Electronic Remittance Advice Rates for Carriers	Completed analysis of baseline data	32.96%	37%	Goal Met 44.02%	45%	Goal Met 46.13%	46%
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
Long Term Objective: Implement Medicare Contracting Reform								
MCR 13.1	Award Medicare FFS Workload to MACs	Delivered Report to Congress	Award 9.1%	Award 54.1%	Award 22.2%	Award 79.6%	Award 62.3% Goal not met	Award 100%
MCR 13.2	Implement Medicare FFS Workload to MACs	N/A	N/A	Implement 8.1%	Implement 9.1%	Implement 54.4%	Implement 40.6% Goal not met	Implement 74%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: Mature the Enterprise Architecture Program								
MCR 14	Mature the Enterprise Architecture (EA) Program	Goal Met 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	Goal Met	Mature EA Program 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
Long Term Objective: Strengthen and/or Maintain Diversity at all Levels of CMS								
MCR 15	Increase representation 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	Goal Met Increased	Goal Met Increased	Increase	Goal Met Increased	Increase	Partially Met	Increase

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, Carrier, or Medicare Administrative Contractor (MAC). 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 2008 goal when two major releases went into production on March 24, 2008 and September 15, 2008. The September 15, 2008 MAS release included a real-time interface to the systems used by the Fiscal Intermediaries, Carriers, and MACs to process claims and appeals. This enables MAS users to retrieve and import accurate claims information, thereby reducing data input and keying errors.

The FY 2009 goal 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.

CMS is discontinuing the appeals GPRA goal after FY 2009. With the implementation of the QICs for all Medicare parts and the implementation of the MAS, CMS successfully met the appeals GPRA goal.

MCR3: Implement the Medicare Prescription Drug Benefit ("Part D")

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. This metric was pertinent when CMS originally rolled out Part D, but it is not pertinent now that the program has matured, and CMS will retire this metric for FY 2009 and beyond. 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 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, CMS collected, analyzed and published the results of performance analysis on the MPDPF tool. 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.

To coincide with the start of the 2008 Annual Enrollment Period to help Medicare beneficiaries choose a Medicare Prescription Drug Plan that is best suited for their needs, CMS published the final 2007 performance measures and report card for Part D sponsors. The information provided in the report card encompassed a number of measures falling into 3 categories: customer service, access to medications, and pricing information. CMS refreshed this information in April 2008. For the FY 2009 target, we are planning to add "patient safety" measures, and refine and refresh all report card measures. Due to the successful launch and operation of the Part D program, this metric is no longer pertinent and will be discontinued following FY 2009.

For the enrollment performance measure, the data is now reported in terms of fiscal year instead of calendar year (CY), as previously reported. This change reflects our effort to be consistent in reporting fiscal year data. The baseline for FY 2007, which represents CY 2006 enrollment data, was approximately 90 percent. This reflects the initial success of the Medicare prescription drug program. FY 2008 data also reported 90 percent. As a result, the FY 2009 target was set at 91 percent. By FY 2010, the target will be increased to 92 percent.

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. The prevalence of physical restraints in nursing homes in an indicator of quality of care and may be considered a quality of life measure for nursing home residents. Since 1996 the prevalence of restraints has declined from a baseline of 17.2 percent. In FYs 2006 and 2007, CMS exceeded its target of 6.4 and 6.2 percent with an actual of 6.1 and 5.0 percent respectively. As a result of the reduction in restraints use from FY 2006 to FY 2007, about 15,000 fewer nursing home residents are physically restrained each day. This measure was included in the FY 2006 Medicaid PART.

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 homes in the new national campaign entitled *The Advancing Excellence in America's 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. Despite the exceptional progress that we have made, we expect that the future rate of decrease will diminish as more and more nursing homes meet targeted rates.

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. The prevalence of pressure ulcers in nursing homes is an indicator of quality of care and may be considered a quality of life measure for nursing home residents. After

many years of little or no progress, CMS has met its targets since FY 2004, including FY 2007, where we exceeded our target of 8.6 percent with an actual prevalence of 8.1 percent.

We are encouraged by recent downward trends--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. However, we are not yet certain that the trend will last. The prevalence of pressure ulcers is increased if hospitals discharge patients to nursing homes in less stable conditions. While FY 2006 results exceed future targets, the decrease from FY 2006 to FY 2007 was only 0.1 percentage points. We have therefore set the FY 2008 target at 8.5 percent, and FY 2009 at 8.2 percent.

The CMS Regional Offices have taken a more prominent role in pressure ulcer reduction initiatives with activities that include monthly teleconferences to discuss problems and progress with this initiative. New survey guidance and follow up with States has increased the focus on pressure ulcer reduction. Greater collaboration between State survey agencies and Quality Improvement Organizations (QIOs) is having a positive impact. *The Advancing Excellence in America's Nursing Homes Campaign* and the QIO 9th Scope of Work should help continue the momentum. Finally, CMS has selected 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.

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 have the dollar value of "non-delivered surveys" deducted from their subsequent allocation. 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. CMS issues directions to States outlining the agency's policies and the statutory survey frequency requirements. These communications also prioritize 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 through the State Performance Standards System. CMS uses this 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 challenges include: increases in the number of providers requiring onsite surveys, new responsibilities (such as surveys of transplant programs) and other uncertainties at both the Federal and State levels. In light of these challenges, CMS has sought to promote the highest possible State survey performance by 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. States that do not complete all required surveys have the dollar value of "non-delivered surveys" deducted from their subsequent allocation. 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. Routine surveys are used 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.

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 directions to States outlining the agency's policies and the statutory survey frequency requirements. These communications also prioritize 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 (through the "State performance Standards System (SPSS)"). CMS uses this 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 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 challenges include: increases in the number of providers requiring onsite surveys, new responsibilities (such as surveys of transplant programs) and other uncertainties at both the federal and State levels. In light of these challenges, CMS has sought to promote the highest possible State survey performance 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 statutorily 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.

CMS exceeded its FY 2008 target of 70 percent, with an actual rate of 75 percent. The FY 2009 target is 75 percent. 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 directions to States outlining the agency's policies and the statutory survey frequency requirements. These communications also prioritize 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 through the State performance Standards System. CMS uses these 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.

MCR9: Improve Beneficiary Telephone Customer Service

Beneficiary telephone customer service is a central part of CMS' customer service function. A CMS Quality Call Monitoring process is used by the Beneficiary Contact Center (BCC) to evaluate each Customer Service Representative's (CSR's) performance in responding to Medicare beneficiary telephone inquiries. The BCC is responsible for evaluating and scoring each CSR's performance in handling four telephone inquiries each month using the quality standards of privacy act, knowledge skills, and customer skills. The BCC has exceeded the FY 2008 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.

In the future, the target setting methodology will remain the same, but by FY 2009, the BCC performance, in meeting quality standards, will be assessed by an independent quality assurance (IQA) contractor using a revised scorecard with new scoring logic. The intent of this change is to gather more detail on where improvements can be made in handling telephone inquiries to better serve the Medicare beneficiary population. There is currently a parallel effort between the BCC and the IQA contractor to assess quality through quality monitoring tools – but for separate purposes. The BCC contractor uses Quality Call Monitoring for coaching individual CSRs. Alternatively, CMS' IQA contractor uses Quality Call Monitoring to assess quality from a global perspective as well as to identify processes and areas needing attention and make specific recommendations regarding quality improvements. Part of the IQA Plan addresses quality oversight of English and Spanish inbound and outbound telephone and written

correspondence, as well as e-mail, web chat, and faxed inquiries. CMS will use the results of the IQA audits for root cause analysis and identifying areas of improvement to training and content materials as well as any other tools currently available to CSRs.

Due to the successful development and maintenance of the Virtual Call Center Strategy (VCS), the VCS measure will be discontinued after FY 2008.

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 2008 target for Medicare intermediaries (95 percent) and carriers (95 percent), by reaching levels of 99.8 percent and 98.8 percent, respectively. It is important to note that data for MACs is included in these results, and is divided by workload between the Intermediary and Carrier lines. For FY 2009 and FY 2010, we will maintain payment timeliness targets 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.

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 remittance advice transaction (ASC X12N 835) accomplished electronically, rather than using paper format, telephone, or through another manual process. Electronic Remittance Advice (ERA) is a notice of payments and adjustments sent to providers, billers, and suppliers. A Medicare contractor produces the ERA once a claim has been finalized. The ERA may serve as a companion to a claim payment(s) or as an explanation when there is no payment. The FY 2008 ERA targets were met. Actions like improving the quality and consistency of ERA across the board, and continuously enhancing free software for ERA based on user feedback, have contributed to us reaching the targets. Continuous monitoring and taking quick and effective corrective actions have helped to raise confidence in ERA among providers/suppliers. Because providers/suppliers can automate their systems to review and post payments, take follow-up actions faster, and avoid expensive errors, the overall success of this goal leads to reduced costs and increased efficiency for both CMS and the provider/supplier community.

CMS is in the midst of the Medicare Administrative Contractor (MAC) transition that will continue for the next couple of years. This effort may impact the level of ERA and make it quite challenging for CMS to continue at the current level. We are taking all possible steps to ensure that the ERA related tasks are included in the new MAC contracts, and the MACs are aware how ERAs, as compared to paper remittances, result in cost savings for them so that the transition impact on the level of ERA, if any, is minimal. The ERA targets for this goal include MAC data, which is divided by workload between the Intermediary and Carrier lines.

CMS is also in the process of implementing the next version of EDI standard for ERA that is expected to be adopted by the Secretary as the next Health Insurance Portability and Accountability Act standard. The Notice of Proposed Rulemaking has been published and the final rule will be published after all comments received have been reviewed and considered. The goal for CMS is to implement the new standard in the most efficient way to optimize the benefits and maximize cost savings for both CMS and the provider/supplier community. This effort may impact the level of ERA in the coming years and add to the challenge to continue at the current level.

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, and budgetary resources 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 2008 target of maintaining an unqualified opinion – a target CMS has met for ten consecutive fiscal years. During FY 2008, CMS continued to improve its financial management performance in many areas. Specifically, CMS was successful in addressing two of the significant deficiencies noted in the FY 2007 audit – Controls Over Trust Fund Draws and Inadequate Oversight of Managed Care Organizations. CMS also effectively transitioned four additional contractors to its Healthcare Integrated General Ledger System (HIGLAS) in FY 2008, bringing the total to fourteen Medicare contractors that have successfully transitioned. HIGLAS is now the system of record for these Medicare contractor sites.

During FY 2008, CMS continued to build upon its implementation of 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.

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.

In FY 2008, CMS implemented 31.5 percent of the FFS workload (across five MAC contracts), bringing the total FFS workload implemented to 40.6 percent. Also, CMS awarded an additional six contracts to MACs, for a total award of 62.3 percent of the FFS workload. (However, CMS has suspended performance on two of these MAC contracts due to GAO bid protests.)

In addition to bid protests, the slippage in the FY 2008 projections for award (17.3 percent behind target) and implementation (13.8 percent behind target) was largely due to the complexity and magnitude of the 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 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, systems constraints, performance and capacity issues at EDCs, and legacy contractor non-renewals. For FY 2009, CMS has reduced its implementation target from 85 percent to 74 percent. MAC award protests have caused months of delays in certain jurisdictions. As CMS makes award on the last set of MAC contracts, there is some potential for additional bid protests.

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.

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 2008, CMS did the following to meet its target: Conducted internal architecture reviews of CMS major investments to ensure compliance with CMS strategic vision. In

addition, the HHS Critical Partner Reviews resulted in above average scores of 4s and 5s in the EA section for FY2010 of the OMB 300; Piloted system census with 5 systems. Based on feedback are refining system census instrument; Participated in HHS EA Program Management Office (PMO) system census workgroup; Began segment architecture development for the Health Care Administration (HCA) Business Area beginning with customer service to assist EA in identifying opportunities for business process consolidation, data sharing and collaboration within CMS and HHS, as well as inform the IT investment decision making process; and began exploring approaches to Service Oriented Architecture (SOA) development and implementation. As a starting point, EA partnered with the Chief Technology Officer (CTO) to conduct SOA training seminars to provide general SOA awareness and its benefits, an understanding of relationship between EA and SOA, and a foundation for SOA terminology and its use within CMS.

For FY 2009, CMS will progress in maturing the Enterprise Architecture by doing the following: (1) establish the necessary management practices, processes, and policies needed for developing, maintaining, and overseeing EA, and demonstrating the importance of EA awareness and the value of employing EA practices within the Agency; (2) continue to refine and expand the EA Repository with the goal to establish it as the Agency–wide master inventory for business and IT assets to support Capital Planning and Continuity of Operations Plan (COOP); (3) integrate EA with CMS' Capital Planning and Investment Control (CPIC) process as an essential ingredient to planning and executing an effective IT investment process; (4) continue to develop the Health Care Administration (HCA) Business Area using a segment architecture development approach as defined by HHS; (5) develop and implement an Agency Wide Service Oriented Architecture (SOA) Approach; and (5) capture the CMS As-Is and Target Data Architectures for major business services in order to support transition planning efforts to the IDR.

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, special emphasis programs and related activities as we strive to achieve the thresholds established by the National Civilian Labor Force (NCLF).

For the fiscal year ending 2008, the size of CMS' permanent workforce decreased by 3.94 percent overall. Correspondingly, the net change for the following demographic groups are as follows: Hispanics -13.39 percent, African American -2.11 percent, American Indian -18.0 percent, and all men -5.03 percent. Asians were the only group with a positive net change of 5.93 percent. Non-white EEO groups accounted for 36.3 percent of the CMS permanent workforce in FY 2008 compared to 35.4 percent in FY 2007. This exceeds the overall representation as reflected in the NCLF of 27.2 percent (based on 2000 Census statistics). Women comprised 67.2 percent of the total CMS permanent workforce in FY 2008, compared to a NCLF representation of 46.8 percent. Additionally, the FY 2008 participation rates of African American females, American Indian females, Asian American females, and White females in the CMS permanent workforce meet or exceed their 2000 NCLF cohort participation rates.

Hispanics, African American male and White male representation at CMS is again below the NCLF. 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 Asian (4.88 percent) representation at year end.

Regarding employees with targeted disabilities, CMS has experienced a net change in FY 2008 of -8.5 percent. This has resulted in a participation rate of 1.74 percent compared to 1.83 percent in FY 2007 (from 82 employees to 75). CMS continues to have challenges in the recruitment, hiring, and retention of individuals with targeted disabilities in the CMS workforce. The agency developed a special multi-pronged program plan for the recruitment; hiring and advancement of individuals with targeted disabilities for FY 2008, but the overall reduction in FTEs translated into significant limits on these initiatives.

To improve retention rates, CMS has its mentorship program in place for 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 continues to measure itself against the standards established by the EEOC to achieve a model EEO program where every employee is free from employment barriers.

Medicaid

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term-Objective: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Program								
MCD 1.1	Estimate the Payment Error Rate in the Medicaid Program	N/A	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.	Goal met.	Report national error rates in the FY 2009 PAR based on 17 States measured in FY 2008.	Nov-09	Report national error rates in FY 2010 PAR based on 17 States measured in FY 2009.
MCD 1.2	Estimate the Payment Error Rate in SCHIP	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.	Goal met.	Report national error rates in the FY 2009 PAR based on 17 SCHIP States measured in FY 2008.	Nov-09	Report national SCHIP error rates in FY 2010 PAR based on 17 States measured in FY 2009.
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 Improvement Program								
MCD 2	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 Improvement Program.	N/A	N/A	Baseline (0 states)	Goal met.	15% of States (8 States)	Goal met.	18% of States (9 States)
Long Term Objective: Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)								
MCD 3	Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	N/A	43.6%	Baseline	Mar-08	45%	Mar-09	46%
Long Term Objective: Percentage of Beneficiaries who Receive Home and Community-Based Services								
MCD 4	Percentage of Beneficiaries who Receive Home and Community-Based Services	N/A	N/A	Baseline	Sep-09	+3% over FY 2007	Sep-10	+3% over FY 2008
Long Term Objective: Percentage of Section 1115 demonstration budget neutrality reviews completed								
MCD 5	Percentage of Section 1115 demonstration budget neutrality reviews completed	N/A	Baseline 100%	N/A	N/A	92%	Mar-10	94%

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: Medicaid Integrity Program, Percentage Return on Investment								
MCD 6	Medicaid Integrity Program, Percentage Return on Investment	N/A	N/A	N/A	N/A	>100%	Jan-09 (partial year)	>100%

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 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 were 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 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 Improvement Program

The purpose of this 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. In FY 2007, the baseline year, CMS began a thorough review of data sources and data collection tools to document State quality activities. Comprehensive, individualized Quality Assessment Reports (QARs), the primary vehicle for improving States' ability to assess quality and access to care, were developed for both informational purposes and validation of State quality activities. CMS completed eight QARs to meet its FY 2008 target. CMS is also on target to complete nine QARs in FY 2009.

CMS held brainstorming sessions with States in late FY 2008, and developed a draft Medicaid National Quality Framework. CMS formally launched its development during

the fall 2007 National Association of State Medicaid Directors conference. The framework 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.

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. 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 2009.

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

This measure was developed as a result of the Medicaid Program Assessment Rating Tool (PART) discussions and is a new measure for FY 2008. There is evidence that home and community-based services (HCBS) are more cost-effective than institutional care. Most HCBS are provided under §1915(c) waivers, which are required to limit aggregate HCBS costs to less than the average institutional service the individual would otherwise receive. The Government Accountability Office found that the shift in home and community-based care has allowed some States to provide services to more people with the same dollars available. Beneficiaries experience more person-centered care and improved quality of life under HCBS compared with institutional services at the same level of care. The Deficit Reduction Act of 2005, through several of its provisions, acknowledged and reinforced the value of home and community-based services as alternatives to institutional care. DRA Section 6086 established new authority under §1915(i) for States to offer home and community-based services through their traditional Medicaid State plan program, without a Medicaid waiver. 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 §1915(c) HCBS waivers, including a web-based application and published, consistent, review

criteria; Education and technical assistance outreach to help states implement §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 §1915(j) self-directed services, §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 was100 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 was 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 Deficit Reduction Act of 2005* 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.

CMS has made good progress toward developing the MIP. CMS hired 92 full-time employees by the end of FY 2008 and plans to hire the remaining employees by the

third quarter of FY 2009. CMS hired audit and review and education contractors. In collaboration with the United States Department of Justice, CMS established the Medicaid Integrity Institute to provide State employees with a comprehensive program of course work encompassing all aspects of Medicaid program integrity. CMS has also developed computer algorithms for analysis of State Medicaid claims data and identification of fraud trends.

Medicare Benefits

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive								
MCR 1.1a	Percent of beneficiaries in Medicare Advantage (MA) who report access to care	N/A	Goal met (Trend) – 89.9%)	Set baselines/ targets	Goal met	90%	89.7%	90%
MCR 1.1b	Percent of beneficiaries in Medicare fee-for-service (MFFS) who report access to care;	N/A	Goal met (Trend) – 90.8%)	Set baselines/ targets	Goal met	90%	90.0%	90%
MCR 1.2a	Percent of beneficiaries in MA who report access to prescription drugs.	N/A	Goal met (Trend – 92.7%)	Set baselines/ targets	Goal met	91%	92.8%	91%
MCR 1.2b	Percent of beneficiaries in MFFS who report access to prescription drugs.	N/A	Goal met (Trend – 91.0%)	Set baselines/ targets	Goal met	90%	90.6%	90%

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

Passage of the 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 (MFFS). As a result, we developed four related measures to monitor beneficiary satisfaction with access to medical care and prescription drugs for both MA and MFFS. The four specific measures are as follow:

- 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
- 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
- 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
- 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

To meet our FY 2007 target, data on 2006 beneficiary experiences in the new plans were collected in FY 2007 and are reflected in the table preceding this discussion.

Our 2006 baselines are already high, and our future targets are to continue to achieve those high rates at 90 percent or over. The FY 2009 and 2010 targets (90 percent for MA and MFFS beneficiary access to care measures, and 91 percent for MA and FFS access to prescription drugs) demonstrate a commitment by Medicare to assure continually high levels of care satisfaction in measures that are purposeful and meaningful. Medicare will also analyze data at the plan, enrollee subgroup, and geographic levels to assist plans in developing interventions that are both actionable and targeted to maintain or improve measures.

State Children's Health Insurance Program

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: Improve Health Care Quality Across the State Children's Health Insurance Program (SCHIP)								
SCHIP 2	Improve Health Care Quality Across SCHIP	Goal met. Collect core data; use SARTS; Assist States.	Goal met. 25% of States reporting on 4 core perfor-mance measures	Revise template to reflect State improve-ment efforts.	Goal Met	Dissemi-nate best practices	Goal Met	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.
Long Term Objective: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP								
SCHIP 3	Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP.	N/A	Baseline 6,600,000 children	N/A	7,100,000 children	Increase FY 2006 enrollment by 2%	Mar-09	Increase FY 2006 enrollment by 3%
Long Term Objective: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs								
MCD 1.2	Estimate the Payment Error Rate in SCHIP	N/A	N/A	Begin full implement ation of measur-ing FFS, managed care and eligibility in 16 States for SCHIP (excludes Tennes-see) Report national error rate in FY 2008 PAR.	Goal Met	Report national SCHIP error rates in the FY 2009 PAR based on 17 States measured in FY 2008.	Nov-09	Report national SCHIP error rates in FY 2010 PAR based on 17 States measured in FY 2009.

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

The purpose of this measure is to improve health care quality across SCHIP. Since its inception, States have shown dramatic improvement in reporting SCHIP performance measures. CMS intensified its efforts to provide targeted technical assistance to States regarding the development and reporting of performance measures, including quality improvement efforts. 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 met the FY 2008 target to disseminate best practices to States. CMS analyzed States' responses to four clinical performance measures and communicated findings to States. In addition, six promising practices from four States were posted to the CMS website. Since the first quarter of FY 2008, CMS has also provided technical assistance to 15 States. CMS has also provided States with a reporting "checklist" on performance measures and has included SCHIP performance quality improvement information in the Medicaid Quality Assistance Reports provided to States, (see MCD2).

The FY 2009 target is to identify States that have low performance rates in targeted measures and provide them with technical assistance, based on best practices, to facilitate quality improvements. CMS identifies a "low performer" as any State that doesn't provide quantifiable and measurable performance measures in their FY 2006 SCHIP annual report. Through this measure, States have the opportunity to benchmark their programs with promising practice activities to continuously improve the quality of care for SCHIP beneficiaries. Nonetheless, many factors could impact the success of this measure. States programmatic changes, reporting accuracy, and timeliness and Federal SCHIP reauthorization programmatic changes are factors that could impact this measure.

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. To accommodate unrelated fluctuations in future Medicaid data, the new measure will only address increases in SCHIP enrollment.

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 FY 2008 target is to increase enrollment of targeted low-income children in SCHIP by two percent over the FY 2006 baseline of 6,600,000 children and the FY 2009 target is to increase enrollment by three percent over the FY 2006 baseline. Many factors will affect SCHIP enrollment, including States' economic situations, programmatic changes, enrollment reporting accuracy and timeliness, and the legislative reauthorization of SCHIP. Congress extended SCHIP, at existing funding levels, through March 31, 2009 while it works through programmatic updates for reauthorization. The FY 2009 target may be impacted by changes made to SCHIP as Congress considers reauthorization of the program.

Health Care Fraud and Abuse Control/Medicare Integrity Program (MIP)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
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	5.2%	4.4%	4.3%	3.9%	3.8%	3.6%	3.5%
Long Term Objective: Improve the Provider Enrollment Process								
MIP 2.1	Develop and Implement Provider Enrollment Chain and Ownership System (PECOS)-Web	Redesign provider enrollment applica-tions; continue web-enabled enrollment process; Establish an acceptable level of pending enrollment actions and maintain the level of inventory	Published revised enrollment applica-tions for all provider and supplier types and continued to make enhance-ments to PECOS	Continue making enhance-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	Goal Not Met Implemen-tation will be delayed until FY 2009	Implement PECOS-Web for DMEPOS suppliers and continue making enhance-ments to PECOS
MIP 2.2	Maintain Fee-for-Service Processing Timeliness Standards	N/A	N/A	Maintain fee-for-service processing timeliness standards	Goal Not Met	Maintain fee-for-service processing timeliness standards	Goal Met	Maintain fee-for-service processing timeliness standards
MIP 2.3	Implement Provider Enrollment Appeals Process	N/A	Consistent with section 936 of MMA developed Provider Enrollment Appeals Process	Publish proposed rule regarding Provider Enrollment Appeals Process	Proposed rule published March 2, 2007	Publish final rule that imple-ments Provider Enrollment Appeals Process	Goal Met: Final Regulation (CMS-6003-F) published on June 27, 2008	N/A
MIP 2.4	Publish a Medicare Enrollment Regulation	Publish final 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 (VDSA) with Insurers or Employees								

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
MIP 3	Improve the Effectiveness of the Administration of MSP Provisions by Increasing the Number of VDSAs with Insurers or Employees	Goal met. 26 additional VDSAs	Goal met. 23 additional VDSAs	Sign 8 additional VDSAs	Goal met. 11 additional VDSAs	Sign 8 additional VDSAs	Goal met. 19 additional VDSAs	Goal discon-tinued
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	89.6%	82.8%	75%	78.7%	85%	Early 2009	90%

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 2008 paid claims error rate was 3.6 percent; exceeding the 3.8 percent target by 0.2 percentage points. CMS activities were more effective than expected in reducing the error rate. In light of this unexpected result, the target for FY 2009 has been adjusted to continue to pursue aggressive

reductions in the FFS error rate. The FY 2008 error rate was reported in November 2008.

To strengthen our confidence in CERT review findings and assure the accuracy of reported error rates, CMS began an effort to independently perform blind, random reviews of its CERT review contractor's payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete.

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.

Beginning with the 2009 report cycle the CERT program will sample, review, and report on inpatient hospital claims that were previously measured by the Hospital payment Monitoring program (HPMP). The addition of these claims into the CERT program increases the comparability of rates between Medicare programs by streamlining error rate calculation and program methodology. This transition also aligns the oversight of inpatient hospital claims with that of all other Medicare FFS provider types, allowing better prioritization of problems and more efficient use of error prevention efforts.

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.

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 providers and suppliers that bill fiscal intermediaries, carriers or an A/B Medicare Administrative Contractor (A/B MAC). Medicare fee-for-service contractors and A/B MACs 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 2009, we believe that contractors will be able to meet or exceed established processing standards. Established processing standards for paper applications require contractors to process 80 percent of initial enrollment applications within 60 days, and 80 percent of changes and reassignments within 45 days.

In FY 2008, we finalized the provider enrollment appeals regulation on June 27, 2008 and maintained processing timeliness standards.

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

Once PECOS Web is implemented in FY 2009, the initial intensive portions of this measure will be met, therefore this goal is being discontinued for FY 2010 and beyond. CMS will continue to enroll, update and revalidate providers and supplier to ensure that all providers and suppliers continue to meet Federal regulations and State licensing requirements.

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 2008 goal by signing 19 additional VDSAs.

In light of Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), which requires mandatory data sharing as of January 1, 2009, the Coordination of Benefits Coordinator will not pursue new VDSAs with Insurers as of FY 2009. As a result, this goal will be discontinued following FY 2008.

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. Each CERT participating Medicare contractor worked on educational and procedural elements to help reduce the error rate in their jurisdiction. Refinements in the CERT process played a minor role in reducing contractor specific error rates. Improvements in the documentation submission process helped contractors avoid no-documentation and insufficient documentation errors. FY 2008 results will be available in early 2009.

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 Hospital Payment Monitoring (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.

State Grants and Demonstrations

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: **Accountability through Reporting in the Medicaid Infrastructure Grant Program**								
SGD1	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	Annual Report produced	Annual Report	Goal Met	Annual Report	Goal Met	Annual Report

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 2008 target, the third of these annual reports was prepared, summarizing the progress of Medicaid Infrastructure Grant (MIG) States during calendar year 2007. The report is available at: http://www.cms.hhs.gov/TWWIIA/03_MIG.asp#TopOfPage, and 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.

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 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: Improve Cytology Laboratory Testing								
CLIA1	Percent of pathologists receiving a passing score in gynecologic cytology proficiency testing	88% (CY 2005 baseline)	93.7% (CY 2006)	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%	Data available August 2009	94%

CLIA1: Improve Cytology Laboratory Testing

There is a direct relationship between a gynecologic cytology test finding and the diagnosis of a specific clinical disease. Gynecologic cytology testing provides the first indication of cervical cancer. CMS' continued commitment to improving cytology laboratory testing helps to improve one of the principal issues in women's health; that is, accurate and reliable gynecologic cytology test results.

As of January 1, 2005, all laboratories that perform gynecologic cytology testing were required to enroll in cytology proficiency testing (PT). CMS began collecting cytology PT data in CY 2005 to determine the percent passing rate of all pathologists tested in gynecologic cytology PT, both those working with a cytotechnologist and without the aid of a cytotechnologist.

Testing Cycle period	All pathologists (combined) tested in gynecologic cytology PT	Percent with Passing score of 90% or greater
CY 2005	6280	88.0% (5554)
CY 2006	6197	93.7% (5809)
CY 2007	6200	95.9% (5950)

Beneath the overall numbers are two phenomena:

a) Pathologists who work without the aid of a cytotechnologist have had a very low passing rate on the initial proficiency test that has been of considerable concern to CMS. However, continued proficiency testing shows a positive trendline with the passing rate on the initial test rising from 67 percent in 2005 to 83 percent in 2006, and to 89 percent in 2007.

b) Pathologists who work with a cytotechnologist have had a higher passing rate than those who screen cytologic specimens alone. With continued proficiency testing the trendline is also positive, rising from a 90 percent passing rate on the initial test in 2005 to 95 percent in 2006 and to 97 percent in 2007.

As a result of CMS' educational approach and intervention, including remediation with resulting increase in knowledge and skills, the pathologists' performance showed improvement from 2005 to 2006. We expect at least 93 percent of all pathologists to also obtain a passing score of 90 percent in FY 2008.

There is high Congressional interest in cytology proficiency testing and the College of American Pathologists continues to lobby for its elimination. In February 2007, the House introduced HR 1237 to repeal cytology PT and replace it with mandatory participation in continuing medical education. The House passed this bill. The Senate support has also grown and a bill, S. 2510, was introduced in December 2007. This bill is currently pending in the Senate's Health, Education, Labor, and Pensions (HELP) Committee. CMS briefed the HELP Committee in May 2008.

Despite efforts to repeal cytology PT, CMS supports the continuation of cytology proficiency testing.

Quality Improvement Organizations (QIO)

#	Key Outcomes	FY 2005 Actual	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2008 Actual	FY 2009 Target
Long Term Objective: Protect the Health of Medicare Beneficiaries								
QIO 1.1	Increase nursing home sub-population flu Immunization	Trend 73.7%	78.4%	74%	79.2%	79%	Dec-09	80%
QIO 1.2	Increase national pneumococcal Immunization	68.4%	69.6%	69%	71.8%	71%	Dec-09	Discon-tinued
Long Term Objective: Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older								
QIO2	Increase biennial mammography rates in women age 65 years and older	52.1%	52.7%	52.5%	53.2% Goal Met	53.0%	Aug-09	Discon-tinued
Long Term Objective: Improve the Care of Diabetic Beneficiaries								
QIO 3.1	Increase hemoglobin A1c testing rate	Trend 84.3%	Trend 85.2%	85.0%	86.0%	85.5%	Sep-09	86%
QIO 3.2	Increase cholesterol (LDL) testing rate	Trend 78.1%	79.5%	80.0%	80.3%	80.0%	Sep-09	81.0%
Long-Term Objective: Protect the Health of Medicare Beneficiaries								
QIO4	Increase percentage of timely antibiotic administration	77.5%	83.1%	82.0%	88.2%	85.0%	Jun-09	89.0%
Long-Term Objective: Protect the Health of Medicare Beneficiaries								
QIO5	Increase percentage of dialysis patients with fistulas as their vascular access for hemodialysis	40.2%	44.0%	47%	48%	51%	51%	54%

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

The National Center for Health Statistics reported that influenza and pneumonia were the primary causes of death for more than 54,000 adults in 2004. 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.

As a result of the recent positive performance and expected efforts of the Quality Improvement Organizations 9th Scope of Work (SOW) in the area of diversity, we increased our influenza immunization target from 74 percent to 79 percent for FY 2008. We also 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 increased immunization rates.

The FY 2007 nursing home influenza results of 79.2 percent far exceed the FY 2007 target of 74 percent and are a .8 percent improvement from FY 2006 results of 78.4 percent. The rate of improvement is showing signs of leveling off, so the FY 2009 target will remain at 80 percent. To achieve our targets, we will continue emphasis of the performance measures of influenza immunization in the Prevention Theme of the QIO 9th SOW.

The FY 2007 pneumococcal results of 71.8 percent exceeded the FY 2007 target of 69 percent by 2.8 percent, and are a 2.2 percent increase from FY 2006 results of 69.6 percent. Despite efforts for improving the pneumococcal vaccination rate, the pneumococcal vaccination results have only increased by 7 percent from FY 2002 to FY 2007. In addition, recent literature indicates that the pneumococcal vaccination may not be as effective in the elderly population as previously believed. We will further technically evaluate the adult immunization measures.

We are discontinuing the pneumococcal goal after FY 2008 while the QIOs focus their efforts on identifying and using strategies for increasing pneumococcal vaccination rates to meet required targets in the 9th SOW under the Prevention theme. We will continue to measure and address our pneumococcal vaccination progress on through the evaluation of the QIOs' performance, and will report on FY 2008 performance in December 2009.

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 target from 52.5 percent to 53 percent. In addition, we exceeded our FY 2007 target of 52.5 percent with a rate of 53.2 percent. These targets were 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 (SOW), which began in 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 faced several challenges to achieving targets for this goal or for pursuing more aggressive targets. One factor was 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.

There has been a general flattening of rates for mammography. The results for this goal have increased only by one percent from FY 2002 (52 percent) to FY 2007 (53.2 percent). We need to further technically evaluate this goal and these measures. We discontinued this goal after FY 2008 while the QIOs focus their efforts on identifying and using strategies for increasing biennial mammography rates to meet required targets in the 9th SOW under the Prevention theme. FY 2008 data will be available in August 2009. We will continue to measure and address our progress on biennial mammography through the evaluation of the QIOs' performance.

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.

The new CY 2007 result for HbA1c was met with results of 86 percent (Target – 85 percent). The 2008 target is 85.5 percent and the 2009 target is 86 percent. The CY 2007 target for cholesterol (LDL) was met with results of 80.25 percent (target 80 percent). The 2008 and 2009 targets are 80.0 percent and 81.0 percent, respectively. We are further evaluating this goal and these measures, and will determine future strategies for obtaining results. In the 9th Scope of Work, Quality Improvement Organizations (QIOs) will focus on increasing testing rates in minority populations in 33 States. As such, the QIOs will have some influence on raising the overall testing rates in a more focused way. Currently, as the underserved testing rates fall short of those in the general population, this is an important task for the QIOs.

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; and the FY 2007 target of 82.0 percent at a rate of 88.2 percent by 6.2 percentage points. Perhaps most importantly, the practice measured in this goal 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 their 100,000 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 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.

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.)

The FY 2007 rate of 88.2 percent far surpasses the target of 82.0 percent. As a result, we are changing the FY 2009 target to 89 percent from 87 percent and setting the FY 2010 target at 90.5 percent. To achieve our targets, we will continue emphasis of the performance measures of SCIP Infection in the Patient Safety Theme of the QIO 9th Scope of Work, and use the performance measures for continued accountability through public reporting (RHQDAPU) 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 328,000 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.

The FY 2008 target was to have 51 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 335,405 patients who obtain hemodialysis through CMS ESRD benefit, 51 percent or 170,111 had an AVF as their primary method of vascular access. Therefore, CMS met its target which translates to 10,062 additional ESRD beneficiaries receiving AVFs.

The FY 2008 results are a 3 percent increase from FY 2007 results. The annual improvements achieved in FYs 2006, 2007 and 2008 are 3.8 percent, 4.0 percent and 3 percent, respectively. The rate of improvement is beginning to show signs of leveling off. Based on FY 2008 results, the FY 2009 vascular access target is changed from 55 percent to 54 percent, which is a 3 percent rather than a 4 percent increase. This reflects the challenge of obtaining results as the numbers of AVFs increases each year.

CMS met its FY 2008 target by reaching out to providers and 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 serves 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. Barriers remain in placing AVFs; and the placement of AVFs in new patients prior to beginning hemodialysis continues to be a challenge. The rates of catheter use for new hemodialysis patients are around 75 percent while AVF placement rates for new patients are only at 30.2 percent. CMS has engaged Quality Improvement Organizations (QIOs) to work with the ESRD Networks in a sub-national effort within the 9th SOW from August 2008 through July 2011 to improve AVF rates for new patients beginning hemodialysis. The effects of the QIO efforts in ten states should become evident during late FY 2009.

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 2006, analysis by the US Renal Data System (USRDS) estimated that fistula patients incur lower healthcare costs than other hemodialysis patients. A fistula patient utilizes $59,347 per year, while a graft patient

utilizes $71,616, and a catheter patient utilizes $77,093. 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 2009 target, 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 has recently undertaken a 9th SoW Quality Improvement Organization effort in ten states to target improvements in AVF placement for new patients starting hemodialysis. 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.

Agency Support for HHS Strategic Plan

Centers for Medicare & Medicaid Services
Link to HHS Strategic Plan

	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					
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 Findings and Recommendations from Completed 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/performance including program improvement resulting from the evaluation.

GAO High-Risk List Items

CMS has jurisdiction over functions that the Government Accountability Office (GAO) has designated as “high risk”. Below is a summary of the challenges and actions in the plan for improvement in the GAO high risk areas of Medicare and Medicaid.

Medicare Program
Problem: Medicare is the second largest social insurance program in the U. S. with 44.1 million beneficiaries and total gross expenditures of $432 billion in 2007. Medicare faces increasing financial pressure and for the past seven years, this Administration has worked to increase the effectiveness and efficiency of Medicare. With Congress, we've made great strides in modernizing and improving health care benefits. CMS builds on these efforts by updating and strengthening our payment systems, improving vulnerabilities and information control weaknesses in IT management and security, ensuring Medicare/Medicaid dual eligible population enrollment into and coverage by Medicare prescription drug plans, and improving quality of care and efficiency while restraining costs. One of the most effective tools to restrain spending growth is through refinements that more closely align provider payments to the costs of providing efficient, high quality health care services, rather than the number of services.

Goal: -- Refine Medicare payments to ensure they are appropriate. Improve program integrity and reduce improper payments. – Improve Medicare program management. – Strengthen oversight to improve patient safety and quality care.

Challenges/Actions

- **Refine Medicare payments to ensure they are appropriate. Improve program integrity and reduce improper payments:**

  ● Refine Medicare payments CMS implemented important refinements to several payment systems that are believed to result in savings to the Medicare Trust Fund and improve the alignment of payments to the resources needed to provide health care services. CMS implemented important refinements to the Home Health Prospective Payment System and to the Inpatient Prospective Payment System (IPPS). CMS implemented a new competitive bidding program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) in 10 metropolitan areas on July 1, 2008; however, the recent Medicare Improvements for Patients and Providers Act (MIPPA) delayed implementation of the program until 2009. CMS updated the practice expense methodology for the Physician Fee Schedule (PFS). CMS increased the packaging of services in the Outpatient Prospective Payment System (OPPS). CMS implemented a budget neutral revised ambulatory surgical center (ASC) payment system.

  ● Enhance program integrity and reduce improper payments Continue to implement Medicare error rate measurement programs that comply with the Improper Payments Information Act of 2002 (IPIA). Annually report on Medicare (fee-for-service, Medicare Advantage, Part D), error rates and corrective actions, as appropriate. Strengthen Medicare program integrity efforts to reduce improper payments and reduce fraud and abuse. Continue program integrity initiatives to address Medicare vulnerabilities and fraudulent business practices in high risk

geographic areas. Complete the transition to a national Recovery Audit Contractor (RAC) program by 2010. Implement the DMEPOS supplier provider requirement that all obtain accreditation by September 30, 2009.

- **Improve program management: Ensure that CMS information technology security and Information Technology Investment Management (ITIM) policies, procedures, and standards were implemented effectively; ensure effective coverage for the Medicare/Medicaid dual eligible population into prescription drug plans; and improve management of the Medicare program.**

  ● Eliminate vulnerabilities and information control weaknesses in IT management and security 1. Updated and reissued the CMS Policy for the Information Security Program and Acceptable Risk Safeguards in accordance with OMB and NIST guidance. 2. Updated the ITIM policy and guidance, utilizing an updated Strategic Plan to align investments with business needs.

  ● Ensure enrollment and coverage for the Medicare/Medicaid dual-eligible population into prescription drug plans 1. Implemented a policy to facilitate seamless prescription drug coverage for those new dual eligible beneficiaries whose Part D eligibility is predictable – Medicare beneficiaries who subsequently qualify for Medicaid. 2. Ensure beneficiaries are reimbursed for services received during retroactively covered months and assign them to a Part D plan sooner.

  ● Improve management of the Medicare program. 1. The implementation of Medicare contracting reform will contribute to improved management of the Medicare program by providing performance incentives to contractors, increasing payment accuracy, utilizing standardized administration services, and enhancing the information technology platform of the program. 2. In accordance with the 2003 legislation, CMS plans to transfer 100 percent of the Medicare FFS claims workload to the new Medicare Administrative Contractors (MACs) by 2010.

- **Strengthen Oversight to Improve Patient Safety and Quality of Care:**

  ● Strengthen the consistency and effectiveness of standards application and increase the quality of laboratory services. In order to improve the safety and quality of laboratory testing, CMS continues to: 1. Develop new protocols or refinements to surveyor guidance and work with the laboratory industry and stakeholders to ensure a consistent approach to evaluating laboratory compliance. 2. Provide comprehensive educational materials for laboratory providers on the CMS Web site. 3. Implement cytology proficiency testing for individuals who examine Pap smears and take action on those who fail. 4. Improve our ability to respond to complaints concerning laboratory testing by establishing an automated complaint tracking system. 5. Establish Clinical Laboratory Improvement Amendments (CLIA) staffing levels consistent with workload and available CLIA revenues. 6. Establish new protocols for improving oversight of our approved laboratory accreditation organizations.

● Improve oversight weaknesses in nursing home survey and certification programs. 1. In order to improve oversight of the quality of care in nursing homes, CMS continues to: 2. Survey all nursing homes at least once every 15 months. 3. Develop new protocols or refinements to surveyor guidance and work with the nursing home industry and stakeholders to ensure a consistent approach to evaluating nursing home compliance. 4. Publish regulations to ensure that better fire-safety policies and procedures are in place. 5. Publish the names of the most poorly performing nursing homes on the CMS Web site. 6. Provide information for each nursing home, including quality data measurements and deficiencies identified during certification surveys to consumers, families and others on the CMS Web site to help consumers make the best choice for their loved ones. 7. Provide technical assistance through the Quality Improvement Organizations (QIOs) to help nursing homes improve their care.

The full, detailed version of this report can be found in the following link: http://www.hhs.gov/budget/medicareplan.html

Medicaid Program

Problem: GAO over the past several years has taken issue with State financing arrangements for the Medicaid program that they believe are improper, inconsistent with the Federal statute and have shifted the cost of the Medicaid program to the Federal taxpayer. In addition, the GAO has stated that CMS has not developed a financial management strategic plan for Medicaid, incorporated the use of key Medicaid data systems into its oversight of states-- claims, or clarified and communicated its policies in several high risk areas, including supplemental payment arrangements.

Goal: -- Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles -- Determine what systems projects are needed to further enhance data analysis capabilities -- Ensure that waiver programs are financed appropriately -- Improve fiscal integrity and financial management.

Challenges/Actions

- **Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles. Strengthen the fiscal accountability of the Medicaid program. Develop a financial management strategic plan for Medicaid, and incorporate the use of key Medicaid data systems into its oversight of states--claims, or clarify and communicate its policies in several high risk areas, including supplemental payment arrangements:**

  ● Strengthen the fiscal accountability of the Medicaid program. On May 25, 2007, CMS released a final rule to clarify the appropriate Medicaid State financing sources, including the use of intergovernmental transfers and certified public expenditures. The final rule also reaffirms the retention of payment requirements, consistent with the CMS oversight initiative. On June 30, 2008, Public Law 110-252, the Supplemental Appropriations Act, 2008, was enacted; this law prevents the CMS from finalizing and/or implementing the regulation until after March 31, 2009.

  ● Further enhance data analysis capabilities. To address previous barriers to accessing Medicaid Statistical Information System (MSIS) data, we have implemented a Web-based statistical summary, Datamart, which will support review of broad payment patterns and trends. This tool is readily available, and new financial management staff received an introduction to the use of the Datamart tools during their orientation.

- **Ensure waiver programs are financed appropriately. The GAO has repeatedly criticized section 1115 demonstration practices with respect to budget neutrality: programs that increase Federal financial liability beyond what it would have been without the program should not be approved.**

  ● Review section 1115 demonstrations in accordance with program objectives -- The Department of Health and Human Services Secretary has authority to allow states to test new ideas for achieving program objectives. The Department, in conjunction with the Office of Management and Budget, reviews, negotiates, and makes decisions on awarding proposals from States.

● Mitigate section 1115 demonstrations budget neutrality risk -- CMS will continue to provide States technical assistance in accordance with budget neutrality principles and seek ways to improve the process to ensure that approved programs are budget neutral.

- **Improve fiscal integrity and financial management**

  ● Strengthen program integrity The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program and appropriated funds to combat provider fraud and abuse and to provide effective support and assistance to States. As required by the DRA, CMS issued a comprehensive 5-year plan in July 2006 that outlined CMS' organizational structure and initial activities to begin implementing the Medicaid Integrity Program. In December 2007, CMS contracted with eligible entities to conduct claims review, perform provider audits, and identify overpayments. These contractors are known collectively as the Medicaid Integrity Contractors. CMS continues to provide effective support and oversight to States through on-site reviews and technical assistance.

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Data Source and Validation Table

Unique Identifier	Data Source	Data Validation
Medicare Operations		
Appeals MCR2	The Medicare Advantage Organization provides the Independent Review Entity (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 Electronic Media Claim 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 Electronic Data Interchange (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 Technical Reference Architecture document: http://www.cms.hhs.gov/SystemLifecycleFramework/Downloads/TechnicalRefArch.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[1] • 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 Improvement Program 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.

[1] 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.
Medicare Benefits		
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.

Unique Identifier	Data Source	Data Validation
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)		
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.

Unique Identifier	Data Source	Data Validation
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 Coordination of Benefits (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 proficiency testing (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.
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.

Unique Identifier	Data Source	Data Validation
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.

Slight Deviations Between Target and Actual Result

"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	MCR1.1a
Medicare	MCR1.2a
Medicare	MCR1.2b
Medicare	MCR3.1a
Medicare	MCR8
Medicare	MCR9.1a
Medicare	MCR9.1b
Medicare	MCR9.1c
Medicare	MCR11.2a
Medicare	MCR11.2b