

STRATEGIC GOAL 3:

Increase the Percentage of the Nation's Children and Adults Who Have Access to Health Care Services, and Expand Consumer Choices

The Department is working to expand health care to all and remains committed to its many efforts aimed at increasing the percentage of the Nation's children and adults who have access to care and expanding consumer choices. The Department will also continue to promote increased access to health care for uninsured and underserved people and for those whose health care needs are not adequately met by the private health care system.

In support of this goal, HHS will continue to promote a wide variety of activities intended to increase access to health care; encourage the development of low-cost health insurance options, reduce health disparities, and to strengthen and improve health care services for targeted populations with special health care needs.

Seven programs are highlighted in this strategic goal including Health Resources and Services Administration's (HRSA) Health Centers Program, HRSA's Ryan White program, Indian Health Service (IHS) National Diabetes Program, SAMHSA Children's Mental Health Services, Centers for Medicare and Medicaid (CMS) Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP).

HRSA's Health Centers program makes available regular access to high quality, family oriented, and comprehensive primary and preventive health care regardless of patients' ability to pay. IHS' National Diabetes program works with communities to prevent and treat diabetes in American Indian/ Alaska Native people. CMS' Medicaid serves as the primary source of health care for a large population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. In coordination with Medicaid, SCHIP has stimulated enormous change in the availability of health care coverage for children. For over four decades, CMS Medicare has helped pay medical bills for millions of aged and disabled Americans and has afforded them with comprehensive health benefits.

Highlighted Programs

- 3a: HRSA Health Centers Program
- 3b: HRSA Ryan White Program
- 3c: IHS National Diabetes Program
- 3d: SAMHSA Children's Mental Health Services
- 3e: CMS Medicaid and the State Children's Health Insurance Program
- 3f: CMS Medicare
- 3g: CMS Medicare Quality Improvement Organizations

3a Health Centers Program

Health Resources and Services Administration (HRSA)

Significance

Health centers are a major component of America’s health care safety net for the Nation’s low-income, underserved, and vulnerable populations. This program, which is over 40 years old, is part of a Presidential initiative to increase health care access for those Americans most in need. This initiative, begun in FY 2002, has the goal of significantly impacting 1,200 communities through the creation of new or expanded access points. Health centers provide regular access to high quality, family-oriented, and comprehensive primary and preventive health care, regardless of patients’ ability to pay, while also reducing other barriers to care. The ultimate goal of the Health Centers program is to contribute to improvements in the health status of underserved and vulnerable populations and to the elimination of health disparities. The three performance measures reported here are key indicators of expanded access to care and increased availability of services for the Nation’s most vulnerable populations.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase the number of uninsured and underserved persons served by health centers.	14.62 M*	08/2007	Deferred
Continue to assure access to preventive and primary care for racial/ethnic minorities.	64% 9.35 M	08/2007	Deferred
Increase the infrastructure of the health center program to support an increase in utilization via: total new or expanded sites.	121	122	Met
Data Source: Persons served: The HRSA/Bureau of Primary Health Care Uniform Data System. Sites: The Bureau of Health Care Delivery and Assistance Network and the HRSA Electronic Handbooks.			

*Revised performance target published in FY 2007 Congressional Justification.

Result Analysis

Health centers served 14.1 million persons in FY 2005, exceeding the target by 100,000 persons. This represents growth of over one million persons from the previous year and growth has increased by nearly four million persons since the beginning of the President’s Initiative.

The number of racial/ethnic minority individuals served by health centers increased from 8.3 million in FY 2004 to nearly 9 million in FY 2005, continuing a steady growth consistent with the overall growth in program clients. The proportion of racial/ethnic minority individuals has remained steady at about 64 percent of total clients, only one percentage point below the FY 2005 target of 65 percent. Some of the new health center sites established under the President’s Initiative are in underserved rural areas that do not have large numbers of racial/ethnic minorities. The substantial and rapid increases in the total number of clients served and expansions in areas with relatively small proportions of racial/ethnic minorities impact the program’s ability to maintain and increase the proportion of minority clients served. Therefore, maintaining a racial/ethnic representation of 64 percent of total clients is an important achievement.

FY 2006 data on patients served will be available in August 2007. These data are reported annually on a calendar year basis. Data are collected each February for the previous year and aggregate reports are finalized in August after an extensive data cleaning and editing process occurs.

To provide additional required facilities, personnel, and services in communities of greatest need, the Health Centers program has funded 899 new or significantly expanded sites between FY 2002 and FY 2006, exceeding the target each year. In FY 2006, 122 new or expanded sites were funded.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Increase the number of uninsured and underserved persons served by health centers	11.32 M	12.4 M	13.1 M	14.1 M	08/2007
Continue to assure access to preventive and primary care for racial/ethnic minorities	64% 7.24 M	64% 7.92 M	63.5% 8.34 M	63.6% 8.99 M	08/2007
Increase the infrastructure of the health center program to support an increase in utilization via: total new or expanded sites	302	188	129	158	122

Data Collection

HRSA-funded health centers report program statistics annually through the Uniform Data System (UDS). The UDS contains a core set of data that is used for program monitoring and performance management. Grantees report data on total patients served, the racial/ethnic composition of their patient population, as well as other demographic, administrative, financial, and utilization information. The data collected and compiled in the UDS are available at the grantee, state, regional, and national levels.

The Bureau of Health Care Delivery and Assistance Network (BHCDANET) is an agency mainframe system with business rules to generate unique grantee and site identifiers. BHCDANET maintains data on all sites that are included in the Health Centers grantees' approved "scope of project" and is updated regularly by Health Centers program staff as new site and scope information is received from grantees. HRSA Electronic Handbooks, a HRSA-wide web based grants management portal, also compiles and maintains Notice of Grant Awards, which are issued when new and expanded site funding is awarded to health centers.

Completeness

All HRSA-funded health centers are required to report to UDS as a condition of their grant award. Technical assistance is provided to health centers to assist them on matters related to the completeness, reliability, and accuracy of data reported to the UDS. The UDS contractor and trained editors edit and clean submitted UDS data using over 1,000 edit checks, both logical (e.g., consistency across data tables and totals) and specific (e.g., significant increases or decreases in certain values). These include checks for missing data and outliers and checks against history and norms. The data are not finalized until all editing and reviewing procedures are completed.

BHCDANET contains hard code editing checks built into the operating platform of the mainframe system. In addition, Health Centers program staff update the data regularly, ensuring its completeness.

Reliability

The reliability of the data is assured in the same way as completeness.

3b Ryan White CARE Act program

Health Resources and Services Administration (HRSA)

Significance

HRSA’s Ryan White CARE Act program serves as the focal point for the Federal response to the primary care and social support needs for poor and vulnerable persons living with HIV/AIDS. The program targets funding toward the development of an effective service delivery system by partnering with States, heavily-impacted metropolitan areas, community-based providers, and academic institutions. Specific HIV/AIDS health services include medical care, access to life-saving medications for the treatment of HIV/AIDS, dental care, outpatient mental health services, outpatient substance abuse treatment, and home health care.

An important component of the care provided is informing persons of their serostatus (HIV status) following testing. This is essential for the program’s efforts to get infected persons into appropriate HIV-related medical care and for efforts to contain the spread of the disease. Much has changed in the epidemiology and medical management of HIV/AIDS since the Ryan White CARE Act was enacted in 1990. The Centers for Disease Control and Prevention estimates that 1.039 million to 1.185 million people in the United States are living with HIV/AIDS, of whom an estimated 24 to 27 percent are unaware of their serostatus. When combined with the number of people who know their serostatus but who receive care intermittently at best, it is clear that hundreds of thousands of people living with HIV/AIDS in the United States are not receiving care in keeping with current treatment guidelines. While it used to be that those diagnosed with the disease had little hope, patients today are living longer and healthier lives due to the benefits of early treatment. The program aims to increase annually the number of persons who learn of their serostatus through Ryan White CARE Act service providers.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act programs	2% over FY 2005	02/2008	Deferred
Data Source: Ryan White CARE Act Data Report			

Result Analysis

In FY 2004, the CARE Act provided 553,569 persons confirmation of their serostatus. This represents an increase of 23 percent (102,641 persons) over the previous year and exceeded the FY 2004 target by 20 percent. The FY 2005 and 2006 data will be submitted by grantees and service providers by mid-March 2006 and 2007, respectively. The 2005 and 2006 data submissions are followed by various internal and external data quality checks, and the actual results are expected in February 2007 and 2008, respectively.

Performance Measure	Fiscal Year Actual				
	2002	2003	2004	2005	2006
Increase by 2 percent annually the number of persons who learn their serostatus from Ryan White CARE Act programs	N/A	450,928	553,569	02/2007	02/2008

Data Collection

The Ryan White CARE Act Data Report (CADR) is completed by all Ryan White CARE Act funded grantees and service providers. The specific CADR item for the performance measure reported here asks grantees to: “Indicate the number of individuals who, after being tested for HIV antibodies, returned for HIV post-test counseling from an individual qualified to provide such counseling, during the reporting period, regardless of their test results. This includes every individual tested for HIV, whether the test result was positive, negative, or indeterminate.” All CADR data are submitted electronically on an annual basis through a single HRSA-mandated reporting portal known as the HRSA Electronic Handbooks.

Completeness

All CARE Act grantees and their service providers are required to report annual CADR data as a condition of their grant award. Data completeness, accuracy, consistency, and reliability are ensured by two types of data quality checks. First the CADR data as entered by grantees are checked through a series of automatic edit checks that are built into this electronic data reporting and management system. Entered data cannot be accepted and submitted until these internal checks are completed and any problems resolved. In addition, data quality checks are performed by project officers and data specialists who monitor and review the CADR submissions with the goal of providing technical assistance to grantees, when needed, to improve data quality.

Reliability

Reliability is checked in the same way as completeness.

3c National Diabetes Program

Indian Health Service (IHS)

Significance

The IHS National Diabetes Program, now known as the Division of Diabetes Treatment and Prevention, was authorized by Congress in 1997 in response to alarming trends documenting a disproportionately high rate of type 2 diabetes in American Indian and Alaska Native (AI/AN) communities. It came in the wake of increasing public concern about the human and economic cost of diabetes in the United States, and the growing prevalence among the AI/AN population. The Division of Diabetes Treatment and Prevention strives to bring Tribes and Urban Indian health programs together to share information and work towards a common purpose of improving diabetes care and outcomes. Quality diabetes care centers on blood glucose control, blood pressure control, and maintenance of normal blood cholesterol levels. Keeping these parameters within normal limits in a person with diabetes reduces microvascular and macrovascular complications. Please refer to the following website www.ihs.gov/MedicalPrograms/Diabetes for more details.

Glycemic control is one of the sentinel measures for diabetes care, and refers to how well the blood sugar levels are controlled in a person with diabetes. The sugar level is measured with a blood test called the Hemoglobin A1c, and results are categorized into the following levels: “Ideal” (<7 percent); “Good” (7.0-7.9 percent); “Fair” (8.0-9.9 percent); “Poor” (10-11.9 percent); and “Very Poor” (>12 percent). These levels are based on national diabetes care standards. Increasing the number of patients with diabetes within the ideal level lowers health care costs and reduces mortality rates associated with diabetes. Clinical studies show that lower Hemoglobin A1c levels are associated with lower heart-attack rates, lower rates of eye, kidney, and nerve disease, and fewer amputations among people with diabetes. The prevention or delay of such risk factors in people with diabetes provides value to society by improving the overall health status of the AI/AN population.

Performance Measure	Fiscal Year 2006		
	Target*	Actual	Result
Increase the proportion of patients with diagnosed diabetes with ideal glycemic control (A1c<7.0)	36/32%**	11/2006/31%	Deferred/Not Met
Data Source: Diabetic registries; yearly IHS Diabetes Care and Outcome Audit; and Clinical Reporting System extraction of data from local Resource Patient Management System databases.			

*Revised target published in FY 2007 Congressional Justification.

**First figure in Target, Actual and Results columns is Diabetes Audit data; second is Clinical Reporting System data.

Result Analysis

IHS measures glycemic control both by the Annual Diabetes Care and Outcome Audit and by the Clinical Reporting System (CRS). The FY 2006 goal for ideal glycemic control, as measured by the Annual Diabetes Care and Outcome Audit, is to maintain the 2005 rate of 36 percent, this data will be available in November 2006. The FY 2006 goal for glycemic control as measured by CRS is to increase the proportion of AI/AN patients demonstrating ideal glycemic control to 32 percent. Although IHS did not meet the glycemic control indicator based on the CRS data, it did achieve a rate of 31% percent which was a one percentage point improvement over the FY 2005 level. Meeting this target requires costly drug treatment and monitoring as well as patient compliance. Because this rate reflects patient health status rather than the provision of a specific procedure or screening, it is more costly and difficult to effect improvement within a short time frame. However, over a longer period of time, the agency has sustained improvement, increasing the proportion of patients in ideal control by six percentage points since 2002.

Trends Performance Measure	Fiscal Year Actual*				
	2002	2003	2004	2005	2006
Increase the proportion of patients	30%/25%	31%/28%	34%/27%	36%/30%	11/2006/31%

with diagnosed diabetes with ideal glycemic control (A1c<7.0)					
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*First figure shown is Diabetes Audit data; second is Clinical Reporting System data.

Data Collection

In collecting Diabetes Audit data, on-site reviewers use a systematic random sampling technique to obtain a patient sample of sufficient size to provide statistically valid results. Abstracted data from chart reviews is entered locally into a database software program specifically tailored for entering and analyzing Audit data. Regional diabetes coordinators and professional clinical staff members perform the manual reviews, following instructions that use a standard Audit form and uniform set of definitions. The local data files are collected regionally and forwarded for review by the Area coordinator and the DDTP epidemiologist to resolve data errors. The data is then sent to a biostatistician at DDTP, where further error checking routines are performed prior to aggregation and weighting of the data to produce the regional and national summary reports. Following the initial error check and review, the data for each facility are released locally for use in their quality improvement efforts.

Clinical Reporting System (CRS) software passively extracts data from patient records in the IHS health information system (RPMS) at the individual clinic level. CRS is updated at least annually to reflect changes in clinical guidelines for existing measures as well as adding new measures to reflect new health care priorities. Software versions are tested first on developmental servers on large data bases and then are beta tested at facilities, before submission to IHS Software Quality Assurance, which conducts a thorough review prior to national release.

Completeness

Participation in the Diabetes Care and Outcomes Audit is voluntary, although it is strongly encouraged for all Indian health system sites. Participation is a requirement for all SDPI grant recipients that provide clinical care. The vast majority of IHS direct and Tribally administered clinics that provide diabetes care do participate, including multiple sites that have elected to use non-RPMS clinical computer systems. All Indian hospitals participate.

After local sites submit their CRS data, Area coordinators use CRS to create Area level reports, which are forwarded to the national data support team for a second review and final aggregation. These national aggregations are thoroughly reviewed for quality and accuracy before final submission. Specific instructions for running quarterly reports are available for both local facilities and the Area Office.

Reliability

The Diabetes Audit measures are comparable to the measures used for national health outcome indicators, such as the indicators implemented in the National Committee for Quality Assurance’s Health Plan Employer Data and Information Set and the Centers for Disease Control and Prevention’s Healthy People 2010. The IHS has implemented a number of processes, including system wide training, to increase the accuracy and amount of audit data reported.

Electronic collection, using CRS, ensures that performance data is comparable across all facilities and is based on a review of 100 percent of all patient records rather than a sample. Facility reports are submitted on a quarterly and annual basis to the GPRA coordinator for their Area, who is responsible for quality reviews of the data before forwarding reports for national aggregation. Because the measure logic and reporting criteria are hard coded in the CRS software, these checks are primarily limited to assuring all communities assigned to a site are included in the report and to identifying measure results that are anomalous, which may indicate data entry or technical issues at the local level. Comprehensive information about CRS software and logic is at www.ihs.gov/cio/crs/.

3d Comprehensive Community Mental Health Services Program for Children and Their Families (Children’s Mental Health Services)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Significance

The Comprehensive Community Mental Health Services Program for Children and Their Families (Children’s Mental Health Services) provides grants to States, communities, territories, Indian tribes, and tribal organizations to improve and expand their systems of care to meet the needs of children with serious emotional disturbances and their families. From 1993-2004, Children’s Mental Health Services has funded 96 grants in 48 States and two territories, and has provided services to approximately 67,341 children across the United States.

The highlighted performance measure is the percentage of participants with no law enforcement contacts at six months after entering services. This measure reflects positive behavioral outcomes for program participants. Performance on this and other outcome measures can be affected by the mix of grantees in any given year and the particular characteristics of the individuals served.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Improve children’s outcomes and system outcomes: Increase percentage of participants with no law enforcement contacts at six months.*	68%	12/2006	Deferred
Data Source: The Delinquency Survey			

***Of participants” has been added for clarity and is not the exact wording used in the FY 2007 Congressional Justification.

Result Analysis

Data for this measure will be available in December 2006. The most recent year of data (FY 2005) exceeded the established target for that year (53 percent), with 68 percent of children with no law enforcement contacts at 6 month follow-up. Performance on this measure has steadily improved over the last several years.

Performance Measure	Trends				
	2002	2003	2004	2005	2006
Improve children’s outcomes and system outcomes: Increase percentage of participants with no law enforcement contacts at six months*	46.5%	50.5%	67.6%	68.3%	12/2006

***Of participants” has been added for clarity and is not the exact wording used in the FY 2007 Congressional Justification.

Data Collection

The Delinquency Survey, administered to youth 11 years of age and older and caregivers of children up to age 22, gathers information about contacts with law enforcement and delinquent behaviors. Questions are administered in an interview format directly to youth. Data are collected through interviews at baseline and at 6 months after baseline. Responses are entered into a computer-assisted interview program. The data entry program includes quality control checks to enhance the accuracy and completeness of data entered.

The program has established a consistent data collection protocol that is applied across all grantee sites. Extensive materials and training are provided on the protocol are provided. The program documents and monitors data collection procedures at all program grantee sites through a web-based data repository and monitoring system. Data cleaning and quality assessment take place first at each funded community,

and again through the automated system. Data issue reports detailing data errors and inconsistencies are prepared quarterly; local staff then make corrections and resubmit their data to the web-based system at which point data are again reviewed for errors.

Completeness

As described under Data Collection above, data completeness and quality checks are built into the computer assisted data entry submission process. Additional data quality reports are provided quarterly. Interviewer training materials address how to make sure complete data are obtained at the time of the interview. Extensive retention and tracking procedures are implemented at each system-of-care community, including mailings and telephone calls, prompt updating of locator information, and prompt follow-up on returned mail or disconnected telephone numbers. The computerized tracking system prompts staff when specific individuals need to be contacted for follow-up.

The standardized procedures and on-going technical assistance provided to grantees assure high rates of completeness. Across 28 grant communities funded in 2002-2003, staff were able to contact an average of 81 percent of program participants for 6-month follow-up. Of these communities, 8 achieved follow-up data collection rates exceeding 91 percent.

Reliability

SAMHSA staff monitor the status and quality data collection through reports from the automated system. In addition, data staff produce a monthly data collection progress report which is detailed at the site level and semi-annual reports of interview completion rates. Technical assistance is provided to address any data collection problems.

3e Medicaid and State Children’s Health Insurance Program (SCHIP)

Centers for Medicare & Medicaid Services (CMS)

Significance

The State Children’s Health Insurance Program (SCHIP) was created through the Balanced Budget Act of 1997 to address the fact that nearly 11 million American children (one in seven) were uninsured and therefore at increased risk for preventable health problems. Title XXI of the Social Security Act gave States the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. CMS’ goal is to increase the number of children (up to age 19 for SCHIP; age 21 for Medicaid) enrolled in regular Medicaid or SCHIP.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3 percent, or approximately 1,000,000 over the previous year.	03/2007	Deferred
Data Source: Statistical Enrollment Data System			

Results Analysis

In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid and none in SCHIP. Since the SCHIP enrollment goal was initiated in FY 2000, CMS has met the proposed enrollment target each year. For FY 2005, CMS had a target to increase enrollment by three percent or 1,000,000 over the previous year. CMS met its goal and reported a yearly increase of 1,100,000 or 3.1 percent. While final FY 2006 enrollment data for the separate child health programs will be available in October 2006, the final enrollment data for Medicaid expansion and regular Medicaid programs will not be available for CMS review and compilation until the end of January 2007. Final FY 2006 data reports will be available March 2007.

Trends	Fiscal Year Actual				
	2002	2003	2004	2005	2006
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid	+3,100,000	+2,200,000	+2,300,000	+1,100,000 or 3.1%	03/2007

Data Collection

SCHIP regulations require States to report annual/quarterly information no later than 30 days after the end of each fiscal year/quarter. The annual and quarterly report for statistical data is submitted for children enrolled in a separate child health program, a Medicaid expansion program and a regular Medicaid program. Data is submitted through the Statistical Enrollment Data System (SEDS) on the internet. For each program the States report aggregate data on the unduplicated counts of children ever enrolled in the year and each quarter, and for the quarterly reports the aggregate data also includes the number of new enrollees, the number of disenrollees, the number of member months. In addition, the actual number of children currently enrolled on the last day of the quarter is reported. Aggregate data for gender, race, and ethnicity is also required by SCHIP regulations and States report this information on a CMS form in SEDS. Data is analyzed weekly by staff members to ensure that all States have reported necessary information and to ensure the consistency of data. Specifically, staff members review previously submitted state data and compare to current submissions to identify any inconsistencies between time periods. Where inconsistencies occur, staff work with States to identify reasons for inconsistency or provide technical assistance to correct any identified inaccuracies.

Completeness

The SCHIP Statistical Enrollment Data System (SEDS) allows data analysts to view the status of the completeness of each state's reporting for any past Federal fiscal year (FFY) quarter. The SCHIP data analyst monitors the progress the States make to track and report States that have past due data (States must report within 30 days after the end of a FFY quarter). The check for completeness informs CMS whether any state has omitted any required forms. The quality/accuracy check is more subjective, the data analyst is able to identify anomalies in the most recently submitted data compared to past data, and also is able to check for reasonableness, i.e., is the point in time number smaller than the ever enrolled number, is the average number of member months in a quarter less than or equal to three, etc. The primary data limitation is that data is state reported and the interpretation of the SEDS data collection instructions may not be exactly the same across the 50 States and District of Columbia that are reporting. The data is collected and aggregated by each state and reported via the internet into the SEDS. States do not send paper copies of their reports to audit the system for data entry accuracy, so the reliability of the data is dependent on each state's data collection, aggregation, and input into SEDS.

Reliability

As described above, CMS ensures the reliability of SEDS data by analyzing it on a weekly basis. CMS works to ensure that all States have reported necessary information and the consistency of data. Specifically, staff members review previously submitted state data and compare to current submissions to identify any inconsistencies between time periods. Where inconsistencies occur, staff work with States to identify reasons for inconsistency or provide technical assistance to correct any identified inaccuracies.

3e Medicaid and State Children’s Health Insurance Program (SCHIP)

Centers for Medicare & Medicaid Services (CMS)

Significance

In FY 2002, CMS began working with States to jointly explore a strategy for State and Federal use of performance measures. The Performance Measurement Partnership Project (PMPP) is a course of action developed to use reliable and valid performance measures to quantify and stimulate measurable improvement in the delivery of quality health care. The PMPP is CMS’ first effort to develop performance measures based on consensus and voluntary State participation. Sharing best State practices and opportunities for improved performance reporting is intended to assist States in enhancing their overall State Quality Medicaid Improvement Strategies, which will result in improved services and health outcomes for Medicaid recipients. CMS will use the results from the PMPP as the building blocks for the development of a national framework for Medicaid quality. This framework will be developed in collaboration with States and key stakeholders. Encouraging the use of national recognized performance measurement is an integral part of the agency’s performance goal and the CMS Medicaid Quality Strategy.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Improve Health Care Quality Across Medicaid and SCHIP	<u>Medicaid</u> : Collect, on a voluntary basis, 2003 performance measurement data from a minimum of 13 States, and continue to provide technical assistance to States to improve performance measurement calculation and reporting.	Collected data from 13 States and provided technical assistance.	Met.
	<u>SCHIP</u> : Improve reporting by States on core performance measures in order to have at least 25% of States reporting four core performance measures in FY 2005 Annual Report.	At least 25% of States reported four core performance measures in FY 2005 report.	Met.
Data Source: SCHIP annual reports, State Annual Report Template System, Medical Statistical Information System, and Health Plan Employer Data and Information Set.			

Results Analysis

Medicaid

After several years of data collection evaluation efforts, it is evident that the States continue to have great variation in system capabilities, quality improvement expertise, and performance measurement knowledge. In July 2005, CMS rolled-out the Quality Improvement Road-Map with the vision for “the right care for every person every time.” The road-map outlines system improvement strategies for improving care. The initiative provided a timely opportunity to redefine and refocus the Medicaid Quality Goal. The Performance Measurement Partnership Project will complete measurement of State performance measurement reporting in September 2006 to broaden analysis beyond reporting and identify improvement in overall quality in Medicaid services.

The contractor completed the 2006 final report titled “Thirteen State Medicaid Core Performance Measure Reporting Summary: Highlighting Model Practices.” The report also reflects that additional analyses were performed on trended data through 2004 to support quality improvement goals and implementation of the Medicaid and SCHIP quality strategy.

SCHIP

States have shown dramatic improvement in reporting performance measures since the collection of the FY 2003 baseline data. SCHIP’s target for this goal reflect the next steps – the collection, analysis, and dissemination of States’ quality improvement strategies toward establishing and enhancing quality improvement in SCHIP nationwide.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006
Improve Health Care Quality Across Medicaid	N/A	Reported on meeting results; identify strategy for gauging improvement; implemented recommendations.	Updated timeline to implement recommendations; Identified strategy to improve health delivery/quality; implement recommendations.	Refined strategy; collected 2002 data from 10 states; provide technical assistance.	Collected data from 13 states and provided technical assistance.
Improve Health Care Quality Across SCHIP	N/A	Worked with States on the PMPP; Reported on results of the meeting with States and identified a timeline for implementing recommendations; Identified a strategy for improving health care delivery and/or quality, and specified measures for gauging improvement; Initiated action steps for implementing recommendations; and Began to implement core SCHIP performance measures.	Refined data submission; produced standard measures; collected 2003 baseline data.	Collected core performance measures; used new automated template to evaluate data; provided technical assistance to States.	At least 25 percent of States reported four core performance measures in FY 2005 report.

Data Collection

Data was collected for one year for this report to assess the use of performance measures identified through the Performance Measurement Partnership Program. The data was collected by CMS’ contractor. To identify the ten States included in the report, the contractor performed an extensive Web search for publicly available quality/performance data. The contractor began with the States that were interviewed earlier in 2005 under a separate effort. They then expanded the search to include all 50 States to ensure that best practices were being identified. After identification of the States, the contractor extracted the publicly reported data from the websites and created their own data base for use in the report. Each State included in the report had the opportunity to review the data for accuracy. Recommendations for changes to the report from the States were incorporated as appropriate. A site visit

was recently completed for one of the States listed in the report and supporting documents were obtained to validate the report contents.

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 Medical Statistical Information System (MSIS). States were supportive of the effort, but continued to implement performance measures via other mechanisms, such as 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.

Completeness

During this screening phase, the contractor created a database summarizing materials collected from all States. The contractor combined this information with data from the aforementioned interviews and statistics from CMS regarding State enrollment and managed care penetration. Variables to identify best practices included: performance measure characteristics, years collected and reported, and whether States have implemented performance improvement programs. The contractor selected States that had the greatest depth and longevity of quality measurement, focusing on Health Plan Employer Data Information Set (HEDIS) / PMPP measures. The contractor also looked for States that had implemented interventions and completed re-measurement and/or had Fee-For-Service (FFS) / Primary Care Case Management (PCCM) information available. Sixteen candidate States were identified, of which ten were comprehensively reviewed. There are limitations in the data which are clearly stated in the report. The primary limitation is that the report relies upon secondary data collected by the States which have different methods of validating the data. Four States used a standard validation process while the other processes varied.

Reliability

Management ensured reliability of data by first participating in the evaluation design phase with the contractor and subsequently by directly reviewing a sample of the primary data sources (e.g. reviewing the web based information from which the report was derived). Additionally, each State included in the report had the opportunity to review the data for accuracy. Recommendations for changes to the report from the States were incorporated as appropriate. A site visit was recently completed with one of the States listed in the report and supporting documents were obtained to validate the report contents.

3f Medicare

Centers for Medicare & Medicaid Services (CMS)

Significance

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides all Medicare beneficiaries access to prescription drug coverage can reduce their spending on prescription drugs. CMS has completed the implementation of management processes and IT infrastructure necessary to manage the Part D program. The successful implementation of systems addressing claims, oversight, and contractor management has enabled CMS to implement the Part D program on time and has established the foundation for a strong program management structure that will reliably deliver prescription drugs to Medicare beneficiaries at a reduced price.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Implement the New Medicare Prescription Drug Benefit 1a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006 b. Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs 2. Implement a Part D Claims Data System, oversight system, and contractor management system.	*1. a. 49.4%	67%	Met
	b. 52.5%	69%	Met
	c. 28.4%	50%	Met
	2. Implement a Part D Claims Data System, oversight system, and contractor management system.	2. Implemented a Claims Data System; Improved oversight reduced call center wait times; and implemented Contractor Management System.	Met
Data Source: National Medicare Education Program Assessment Survey			

*Revised target was published in the FY 2007 Congressional Justification.

Result Analysis

The National Medicare Education Program (NMEP) Assessment Survey was completed in September 2006. The new drug benefit was implemented in 2006 and consumers were first surveyed in 2005 to measure public knowledge of the new program. FY 2006 survey targets were developed using FY 2005 results as a baseline. The operational targets have been completed as follows:

Claims Data System: CMS' Drug Data Processing System has been in operation since the launch of the program. Plans were required to submit Prescription Drug Event (PDE) data to CMS by the end of the first quarter and thereafter, PDE records must be submitted to CMS electronically at least once a month.
Program Oversight: On June 26, 2006, CMS issued a press release showing the improvements in plan call center wait times from April 6, 2006 to May 31, 2006. The positive trending of this performance metric was a direct result of CMS' oversight of this issue. On April 14, 2006, CMS published the 2007 Part D

Reporting Requirements, and on April 25, 2006, published the Prescription Drug Benefit Manual on Fraud, Waste and Abuse.

Contractor Management Systems: CMS has implemented a contractor management strategy that assigned an “Account Manager” to each program sponsor. These staff completed the review of plan applications to enter the program. The application is CMS’ first review of a plan’s ability to administer the benefit.

Trends Performance Measure	Fiscal Year Actual				
	2002	2003	2004	2005	2006
Implement the new Medicare Prescription Drug Benefit					
1a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006	N/A	N/A	N/A	a. 47%	67%
b. Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan	N/A	N/A	N/A	b. 50%	69%
c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs	N/A	N/A	N/A	c. 27%	50%
2. Implement a Part D Claims Data System, oversight system, and contractor management system.	N/A	N/A	N/A	N/A	Implemented a Claims Data System; Improved oversight reduced call center wait times; and implemented Contractor Management System

Data Collection

The data source is the National Medicare Education Program Assessment Survey (NMEP), which is a nationally representative telephone survey of approximately 2,000 beneficiaries. The NMEP is intended to increase beneficiary access to, awareness of, understanding about, and use of the information to make appropriate health plan and health care delivery choices.

Completeness

The questions used in the NMEP Assessment Survey have been extensively tested with Medicare beneficiaries and the survey has been tested for reliability and validity.

Reliability

The NMEP Assessment Survey is 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 device.

3f Medicare

Centers for Medicare & Medicaid Services (CMS)

Significance

In response to the need to standardize the measurement of and monitor beneficiaries’ experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Healthcare Providers and Systems (CAHPS) formerly called Consumer Assessment of Health Plans Survey. CMS fielded these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care (later called Medicare Advantage, MA) plan as well as to those enrolled in the original Medicare fee-for-service plan (MFFS).

Passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required modifications in the Medicare CAHPS Surveys to include measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans (PDP) as well as the MA and MFFS health plans.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
Improve satisfaction of Medicare beneficiaries with the health care services they receive	*Develop MMA measures to include in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey	Survey field tested	Met
Data Source: The Medicare Consumer Assessment of Healthcare Providers and Systems			

*Revised target was published in the FY 2007 Congressional Justification.

Results Analysis

Through FY 2005, measures related to access to care and specialist physicians were collected for beneficiaries in Medicare Advantage (MA) plans. Similar measures were collected for enrollees in the Medicare fee-for-service (MFFS) plan through FY 2004, but due to competing funds and in light of the future changes to the Medicare CAHPS, the MFFS survey was not fielded in FY 2005. Although we are unable to determine MFFS performance for FY 2005, FY 2004 results indicate strong performance for the fee-for-service measures, with access to care at 92.0 percent and access to a specialist at 86.9 percent. As a result of the MMA, the focus of this goal now shifts to MMA-related measures. Results from the FY 2005 MA measures show that while we did not reach our target for access to care, we maintained our already high level of performance. We exceeded our target for access to specialists. Data from FY 2006 for the MMA measures will be available in September 2007.

Planning for the new Medicare CAHPS Surveys began in FY 2005 and continued through FY 2006. CMS continued to work with the CAHPS Consortium through the Agency for Healthcare Research and Quality and developed a field test version of the 2006 Medicare CAHPS survey that was implemented in four states in the summer and fall of 2006. The field test results will be used to finalize the survey instruments that will then be implemented nationally in early 2007 and ask about enrollees’ experiences with the Medicare health and prescription drug plans they had in 2006. This developmental performance goal will generate MMA measures that will be used to create new baselines and targets for subsequent years.

Trends	Fiscal Year Actual				
Performance Measure	2002	2003	2004	2005	2006*
Improve satisfaction of Medicare beneficiaries with the health care services they receive. Medicare Advantage: Access to Care Specialist	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	MA Access to care: 90% - MA Specialist: 93%	
Medicare fee-for-service Access to Care Specialist	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	Monitor annual data toward 5-year target	MFFS Access to care/ Access to specialist: Not measured.	
Develop MMA measures to include in the Medicare Consumer Assessment of Healthcare Providers and Systems survey	N/A	N/A	N/A	: N/A	MMA: Goal met

*As a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the focus of this goal for FY 2006 shifted to MMA-related measures.

Data Collection

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS), which is a set of annual surveys of beneficiaries enrolled in all Medicare managed care plans and in the original Medicare fee-for-service plan.

Completeness

CMS fields these surveys annually to representative samples of beneficiaries enrolled in each MA plan as well as those enrolled in the MFFS plan, and provides comparable sets of specific performance measures collected in CAHPS to our partners and stakeholders.

Reliability

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 MA-MFFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.

3g Medicare Quality Improvement Organizations
Centers for Medicare & Medicaid Services (CMS)

Significance

For all persons age 65 or older, the Advisory Committee on Immunization Practices and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Through collaboration among the CMS, the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, efforts are ongoing to improve adult immunization rates in the Medicare population.

In recent years, there have been influenza vaccine shortages and distribution delays, which have impacted the delivery of immunizations. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization, so it is possible that disruptions of influenza vaccine supply also impact pneumococcal vaccination rates.

Based on recent challenges concerning influenza vaccine supply and distribution, a decision was made to change the focus of this performance goal from the general Medicare population to nursing home residents beginning in FY 2006 because of the possibility of achieving a greater impact in the long-term care setting.

Performance Measure	Fiscal Year 2006		
	Target	Actual	Result
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	*Influenza vaccination for nursing home subpopulation: 74%	12/2007	Deferred
	National pneumococcal vaccination: 69%	12/2007	Deferred
Data Source: The Medicare Current Beneficiary Survey			

*Revised target was published in FY 2007 Congressional Justification.

Results Analysis

According to the most recent data (FY 2004), we met our National flu target and fell short of our pneumococcal target. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization. According to the American Medical Association, over 70 percent of pneumococcal vaccine sales in 2002 occurred in the four-month period of August through November. It is possible that disruptions of influenza vaccine supply may have impacted the pneumococcal vaccination rates also. In addition, recent studies published in the May 1, 2003 edition of the New England Journal of Medicine and the July 2003 edition of the Journal of Infectious Diseases question the effectiveness of the pneumococcal vaccine. Such reports may dissuade some health care professionals from offering pneumococcal vaccine for their older patients.

Based on recent challenges concerning influenza vaccine supply and distribution, we are focusing on nursing homes where we may have greater impact. CMS issued a final rule requiring nursing homes to provide residents with the opportunity to be immunized against influenza and pneumococcal disease as a condition of participation in the Medicare and Medicaid programs. CMS' influenza target for FY 2006 reflects this change.

Trends	Fiscal Year Actual*				
	2002	2003	2004	2005	2006
Performance Measure 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	Influenza: 69%	Influenza: 70.4%	Influenza: 72.8%	12/2006	12/2007
	Pneumococcal: 64.6%	Pneumococcal: 66.4%	Pneumococcal: 67.4%	12/2006	12/2007

*FY 2002-FY 2005 Influenza rates represent the general population. FY 2006 Influenza rates specifically represent nursing home population.

Data Collection

Currently, through the Medicare Current Beneficiary Survey (MCBS), annual estimates of immunization coverage among facility-dwelling persons with Medicare are available. CMS will continue to use MCBS data for the pneumococcal target as well as for the nursing home influenza target for FY 2006.

Completeness

MCBS is an ongoing survey of a representative national sample of the Medicare population, includes beneficiaries who reside in long-term care facilities.

Reliability

The MCBS uses Computer Assisted Personal Interview 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.